NASSAU COUNTY DEPARTMENT OF HEALTH OFFICE OF CHILDREN WITH SPECIAL NEEDS APPLIED BEHAVIORAL ANALYSIS

TEAM MEMBER PROGRESS REPORT

Discharge Report □

Child’s Name: Auth. # DOB: IFSP Period: From: To: Agency Name (if applicable): Name of Provider: Discipline: Name of EIOD: Name of OSC:

Date you started working with this child: Frequency/Duration: Where have services been delivered? Number of units not utilized:

Number of units not utilized due to:

Family cancellation: Therapist cancellation:

Has a parent/caregiver been present for the sessions? If not, how have you communicated with the family?

Date of Discharge (if applicable)

PROGRESS TO DATE (*What is specific to your sessions; include behavioral observations and interaction with family.)*

I certify that I have received and reviewed a copy of the child’s IFSP prior to starting services, have provided services in accordance with the IFSP service’s specified frequency and duration and have worked towards addressing the relevant IFSP outcomes. I further certify that my responses in this report are an accurate representation of the child’s current level of functioning.

Signature of Provider completing report: Date : Discipline: Cell phone # License #

Signature of Supervisor/Reviewer: Date :

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