

NYC EARLY INTERVENTION PROGRAM

(Circle One) 3, 6, 9, 12 month

Provider Progress Note PAGE 1

Child's Name: _____ IFSP Period: From ____/____/____ To ____/____/____
(Last) (First)

D.O.B.: ____/____/____ EI #: _____

Provider Agency Name: _____ Provider ID #: _____

Name of Interventionist: _____ Discipline: _____ Service Type: _____

Each Interventionist should receive a copy of this child's IFSP and evaluations immediately upon assignment to work with the child. It is the joint responsibility of the Service Coordinator and the service agency supervisor to ensure prompt delivery of these documents to the interventionist, and it is the responsibility of the interventionist to follow up with his/her agency supervisor if the documents are not received within two weeks of assignment.

Authorization Frequency? _____ Service Start Date: ____/____/____

If there are any gaps in service delivery (i.e., 3 or more consecutively scheduled visits). Describe length and reason for gap in service delivery.

IFSP OUTCOME(S): _____

RATE PROGRESS IN THIS TIME PERIOD

No Progress	Little Progress	Moderate Progress	Great Deal of Progress	Outcome Achieved
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How did you work with the family to help the child to reach this outcome? _____

IFSP OUTCOME(S): _____

RATE PROGRESS IN THIS TIME PERIOD

No Progress	Little Progress	Moderate Progress	Great Deal of Progress	Outcome Achieved
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How did you work with the family to help the child to reach this outcome? _____

IFSP OUTCOME(S): _____

RATE PROGRESS IN THIS TIME PERIOD

No Progress	Little Progress	Moderate Progress	Great Deal of Progress	Outcome Achieved
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How did you work with the family to help the child to reach this outcome? _____

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Provider Progress Note PAGE 2

Child's Name: _____ IFSP Period: From ____/____/____ To ____/____/____
(Last) (First)

1. For the 3 and 9 month report, provide a description of child's progress and current level of functioning. For the 6 and 12 month report, provide the description of progress; in addition, please estimate the percentage of delay at the end of the 6 month and 12 month period and state how that was determined, e.g., criterion referenced instrument, developmental checklist, or clinical opinion. (Standard deviation scores or formal evaluations are not required.)
2. List any factors that limit the collaboration between parent and interventionist. How have you addressed these factors? Be specific.
3. How have you used feedback from the family to help you modify how you work with the family? Be specific and provide examples.
4. Recommendations (include here any new IFSP outcomes, or changes in strategies and activities):

I certify that I have received a copy of the child's IFSP (and evaluation if available). I have provided the services described above in accordance with the frequency and duration mandated by IFSP, and have worked toward addressing the relevant outcomes set forth in the IFSP. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of interventionist completing report: _____ Date: ____/____/____

License No. _____ (If certified interventionist, do not indicate certificate number)

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Child's Name: _____ IFSP Period: From ____/____/____ To ____/____/____ <small>(Last) (First)</small>		
D.O.B.: ____/____/____ EI #: _____		
Name of Therapist/Teacher	Agency	Discipline

For Parent/Caregiver to Complete with Service Coordinator:

- | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | No
Progress | Little
Progress | Moderate
Progress | Great
Progress | Reached
Goal |
| 1. Have you seen positive changes in your child, as a result of EI services? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | |
| | Never | A Few Times | Half the Time | Most of
the Time | Every Week |
| 2. Have you been taught skills, or given ways to help support your child's growth? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | |
| | Never | A Few Times | Half the Time | Most of
the Time | Every Week |
| 3. Do you and the therapist/teacher review which activities are working well and which are not working well? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | |
| | No | Little | Some | Great Deal | |
| 4. <u>For home/community based services:</u> Were the therapists or teachers flexible about scheduling services for you and your child (days, nights or weekends)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <u>For center based services:</u> Did the teacher or therapist keep in touch with you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | | | | | |
| 5. What are your current concerns about your child? Are there new skills you would like to learn? | | | | | |

Signature of Parent/Caregiver: _____

Date: ____/____/____

Signature of Service Coordinator: _____

Date: ____/____/____