

PROGRESS REPORT

TYPE OF REPORT: 6 Month Annual Discharge Transition
 Requested: To request decrease in service To request increase in service 3 mos. after change of Provider Other _____

Child's Name: _____ DOB: _____ CA: _____ DATE OF REPORT: _____

Service Agency: _____ Name of Therapist: _____ Service: _____

Freq/Dur: _____ Service Period: _____ From/To _____ # of Sessions Authorized: _____

of Missed Sessions _____ (Attach supporting documentation, including dates and reasons)

ASSESSMENT OF STRENGTHS AND FUNCTIONAL NEEDS At beginning of service period As of last progress report, dated: _____

- ◆ FUNCTIONAL OUTCOMES ADDRESSED
- ◆ DEVELOPMENTAL SKILL LEVELS (If, appropriate)

MEANS OF ASSESSMENT
(Indicate name of tool used or professional judgment)

PROGRESS ACHIEVED IN AREAS OF FUNCTIONAL OUTCOMES Since beginning of service period Since last progress report, dated: _____

FUNCTIONAL OUTCOMES FOR NEXT SIX MONTHS: (include developmental levels, if appropriate)

RECOMMENDATIONS: Continue with service plan Change in service plan (include rationale) Other (e.g., new evaluations, etc.):

Name of Agency Providing Service _____	Name of Direct Service Provider _____	Type of License/Certificate of Direct Provider & License # _____
Signature _____		