Complete progress reports and review with the parent. Submit the completed report to the service coordinator **no later than 2 weeks prior** **to** **the 6-month** **or Annual review.** All questions must be answered. Illegible hand written reports will be returned. Use additional pages if needed. Typed reports are preferred. Parents should receive copies of session and progress notes.

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| **Child's Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **EI #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB**: \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ **IFSP Period**: From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**Provider Agency Name:** \_\_Important Steps, Inc.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Provider Agency ID #:** \_15248\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Print Name of Interventionist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Discipline:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Service Type:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Interventionist’s Phone Number**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Service Coordinator Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EIOD Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Indicate the language(s) used during the sessions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date reviewed note with parent**: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **Parent’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \*Parent Progress Note is available if parent wants to fill it out. |
| **Authorized Frequency?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date you started working with this child**: \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_  **Where have services been delivered?** ***Home/ Daycare / Facility / Other*** \_\_\_\_\_\_\_\_\_\_\_  **Has the parent(s) been present for the sessions, if not, how have you communicated with the family? *:\_\_\_ Yes\_\_\_No***  **if not, how have you communicated with the family? *Indicate below:***  ***\_\_\_Parents Contacted via phone \_\_\_\_per week/month***  ***\_\_\_Communication Tool Is Used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***  ***\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***  **If there have been any gaps in service delivery of more than three consecutive scheduled visits, describe the length and the reason(s).**  **List the child’s medical diagnosis(es) (if any):**  **Is the child using assistive technologies?**  Yes  No **Is a new AT Device being requested?**  Yes  No  **If yes, identify the type of device, and the Functional Outcome (from the IFSP) and specify how the device is helping (or will help) to achieve the Outcome:** |

**I. Below list all the functional outcomes and objectives *(regardless of your specialty).* Indicate the progress for each:**

**Functional Outcome 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rate Progress in This Time Period**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** NoLittle Moderate Great Deal Outcome

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Progress Progress Progress of Progress Achieved

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Check Y/N to indicate if the objective(s) was achieved in this time period. Check (E) to indicate if the skills related to the objective are emerging.** | | | |
| 1a. Objective: | Yes | No | Emerging |
| 1b. Objective: | Yes | No | Emerging |
| 1c. Objective: | Yes | No | Emerging |
| 1d. Objective: | Yes | No | Emerging |
| 1e. Objective: | Yes | No | Emerging |

**Was this functional outcome and objectives identified at the IFSP meeting? Yes  No**

**If not, the date it was changed :\_\_\_/\_\_\_/\_\_\_ and 2) the reason: (i.e. scope of practice or expertise).**

**IFSP Functional Outcome 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rate Progress in This Time Period**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** NoLittle Moderate Great Deal Outcome

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| --- | --- | --- | --- |
| **Check Y/N to indicate if the objective(s) was achieved in this time period. Check (E) to indicate if the skills related to the objective are emerging.** | | | |
| 1a. Objective: | Yes | No | Emerging |
| 1b. Objective: | Yes | No | Emerging |
| 1c. Objective: | Yes | No | Emerging |
| 1d. Objective: | Yes | No | Emerging |
| 1e. Objective: | Yes | No | Emerging |

**Was this functional outcome and objectives identified at the IFSP meeting? Yes  No**

**If not, the date it was changed :\_\_\_/\_\_\_/\_\_\_ and 2) the reason: (i.e. scope of practice or expertise).**

**IFSP Functional Outcome 3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rate Progress in This Time Period**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** NoLittle Moderate Great Deal Outcome

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Progress Progress Progress of Progress Achieved

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| **Check Y/N to indicate if the objective(s) was achieved in this time period. Check (E) to indicate if the skills related to the objective are emerging.** | | | |
| 1a. Objective: | Yes | No | Emerging |
| 1b. Objective: | Yes | No | Emerging |
| 1c. Objective: | Yes | No | Emerging |
| 1d. Objective: | Yes | No | Emerging |
| 1e. Objective: | Yes | No | Emerging |

**Was this functional outcome and objectives identified at the IFSP meeting? Yes  No**

**If not, the date it was changed :\_\_\_/\_\_\_/\_\_\_ and 2) the reason: (i.e. scope of practice or expertise).**

**2. Describe the learning activities (technique/strategies/method/routine activities) that were successful for the child/family and specify the functional outcomes and objectives related to these activities *(i.e., this question asks about the successes)*.**

***Describe in detail:***

* ***Types of technique/strategies/method/routine activities being integrated within specific routine-based activities the family used to achieve each objective/functional outcome.***

**3. What changes were made to the learning activities (coaching techniques/strategies/method/routine activities) when they were ineffective for the family/caregiver *(i.e., if the child’s progress was limited or if it was difficult for the family to incorporate strategies into their daily routines)*?**

* ***Change(s) to coaching techniques/ /strategies/method/routine activities:***

**When you modified the learning activities, were they successful or if not, why? *\_\_\_\_\_\_ Yes \_\_\_\_\_\_ No* Please address each functional outcome and the relevant objectives as applicable.**

**4. Describe all collaborative efforts made to address the IFSP outcomes (Examples: interaction with other service provider/therapist, day care staff, community resources, and medical providers (with written parent consent)). Please include the family members/caregivers you have been working with.**

* ***Did you communicate with the other EI therapists?: \_\_OT \_\_PT \_\_SLP \_\_SI \_\_SW \_\_Other***
* ***How did you work with the above therapist(s) to achieve the functional outcomes?***
* ***Have you communicated with relevant medical providers (with parental consent)? \_\_\_\_\_ Yes \_\_\_\_\_ No***

***If “yes”, please describe:***

* ***Did you assist the family in finding other resources (e.g., books, articles, educational resources, etc.)? \_\_\_\_\_ Yes \_\_\_\_\_ No***

***If “yes”, please describe:***

* ***Have you communicated with day care staff, taught techniques to grandparents, nannies, etc. who are part of the child’s routine activities? \_\_\_\_\_ Yes \_\_\_\_\_ No***

***If “yes”, please describe:***

**5. Based on your on‐going assessment of the child, what is the overall progress in this child’s functional abilities since the last IFSP meeting or Progress Report? How was progress determined (e.g. standardized instrument, checklist, non-standardized assessments, observation & informed clinical opinion)?**

***Was the standardized test utilized? \_\_\_\_\_Yes \_\_\_\_\_ No***

* ***If “Yes”:***

1. ***Indicate name of the test (e.g., PDMS-2, AIMS, PLS-5, REEL-3, DAYC, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_***
2. ***Report results according to the instrument’s manual:***

* ***raw score(s):***
* ***standard score(s):***
* ***standard deviation:***
* ***If “No”:***

1. ***Indicate tool(s) used (e.g., NYS DOH Memorandum 2005-02 – Standards and Procedures for Evaluations, Evaluation Reimbursement and Eligibility; NYS DOH Clinical Practice Guidelines\_ Communication Disorders; NYS DOH Clinical Practice Guidelines\_ Motor Disorders; E-LAP; HELP Checklist; etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***
2. ***Report functional level in age ranges: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***
3. **Describe the child’s current skills.**

**6. For 6‐Month/Annual Progress Notes only: What skills will you be working on in the next 3 months? Are there new functional outcomes or objectives recommended? The functional outcomes must contain all 6 components (see instructions) and be written in parent friendly language. The new/revised functional outcomes or objectives must be discussed with the parent before submission to NYCEIP.**

***What skills will you will be working on in the next 3 months?***

***Are the majority of Objectives achieved? \_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ No***

***If “Yes”, you should add new functional outcomes and objectives below after discussing w/the parent/caregiver.:***

***IFSP Functional Outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

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| --- |
| ***1a. Objective:*** |
| ***1b. Objective:*** |
| ***1c. Objective:*** |
| ***1d. Objective:*** |
| ***1e. Objective:*** |

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| I certify that I have received & reviewed a copy of the child's IFSP and evaluation/progress notes 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/credentials of therapist completing report**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Print Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **License number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date Report Was Completed:**\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_  ***For CF/COTA****:* ***Signature/cred. of Sup-r responsible for the above provider****:\_\_\_* ***Sup-r’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_******License number:*** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* ***Date Signed:****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |