NASSAU COUNTY DEPARTMENT OF HEALTH EARLY INTERVENTION PROGRAM
APPLIED BEHAVIORAL ANALYSIS
TEAM LEADER PROGRESS REPORT
FAMILY TRAINING

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 authorized: _____ Number of units utilized: _____
Number of units not utilized: _____
Number of units not utilized due to:
Family cancellation: _____ Therapist cancellation: _____

Date of Discharge (if applicable) _____

Family/Caregiver Plan:

a. *Specific suggestions/recommendations for family/caregiver to facilitate attainment of goals:*

b. *Describe family/caregiver involvement:*

c. *Recommendation for future goals:*

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 :_____