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 :_____