SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES DIVISION OF SERVICES FOR CHIDLRENW ITH DISABILITIES – EARLY INTERVENTION PROGRAM

ONGOING SERVICE COORDINATOR PROGRESS REPORT

Child's Name_____ DOB: __/__/__

IFSP Effective Dates: ___/___/___ To___/___/___

This form is required to be completed and sent along with ***all*** of the Provider Progress Reports of the IFSP authorized Early Intervention Services to the EIOD 5 days prior to the six month and annual IFSP meetings.

STATUS OF IFSP: (Indicate specific child/family outcome(s)/service(s) which have been implemented need continued intervention, and/or have not been addressed during the IFSP time frame.)

PARENT PERCEPTION OF SERVICES: (Summarize how parents feel about early intervention services. Do they feel that the current services are meeting their concerns, priorities and child's needs?)

ATTENDANCE: (Has the child been available to receive the services in the frequencies and duration authorized in the IFSP? If the child has missed therapies in excess of 15%, please note reason.)

RECOMMENDATION(S): (List recommendations for continued interventions; recommended changes to service delivery including frequency, duration, and/or location; and additional interventions not previously authorized. Attach all rationale for recommendation(s).)

ATTACHED SERVICE PROVIDER PROGRESS NOTES:

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| [ ] Special Instruction Individual | [ ] OT | [ ] Family Training | [ ] Family Support Group |
| [ ]Special Instruction Group | [ ]PT | [ ] Social Work | [ ] Nutrition |
| [ ]Psychological | [ ]Speech | [ ]Parent/Child Group | [ ]Other_____ |

Number of OSC Units Authorized in Current IFSP_____ and number utilized _____.

_____ _____ ___/____/_____

Signature/Title of Ongoing Service Coordinator | Agency if Applicable | Date