SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES

DIVISION OF SERVICES FOR CHIDLREN WITH SPECIAL NEEDS

EARLY INTERVENTION SOCIAL WORK PROGRESS REPORT

[ ] 3 Month [ ] 6 Month [ ] Discharge [ ] Transition

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| Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Auth.#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  IFSP Period: From: \_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_ Agency Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discipline: Social Work  Name of EIOD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of OSC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date you began working with this child/family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Frequency/Duration:\_\_\_\_\_\_\_\_\_\_\_\_  Where have services been delivered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Number of units authorized: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of units utilized: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Number of units not utilized due to:  Child/family reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist illness/scheduling:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Social work services are being provided to this family to address the following family generated outcomes:  Example:  1. Assist family in navigating their feelings after receiving a diagnosis for their child.  2. Assist family in applying for resources/services such as SSI, Medicaid, NYS OPWDD. |

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Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IFSP from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Objectives addressed during this review period:  Example: Provided information on child’s diagnosis. Assisted family in completing applications for resources. |
| Results of any objectives addressed:  Example: Parent is awaiting response on completed applications. Parent is expressing concerns regarding child. |
| Plan/Recommendations for continued intervention:  Example: Family is requesting services to be discontinued. Assistance is still needed continuation of social work services is recommended. |

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Written Prior Notice: I agree with the therapist who provided this service to my child and assessed my child’s current level of development that my child is no longer in need of this Early Intervention service. I have a copy of my family rights.  Parent’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_ Last Day of Service: \_\_\_\_\_\_\_\_\_\_ |