Westchester gov.com

Early Intervention Program
Department of Health

PROVIDER PROGRESS NOTE

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(Circle One) 6 month 12 month Amendment Discharge

Child's Name: ______________________________ IFSP Period: From ___/___/___ To ___/___/___
(Last) (First)
D.O.B.: _____/_____/_____

Provider Agency Name: ______________________ Name of Interventionist:______________________

License #/Certification/Designation: ______________ Discipline: ______________________

Each Interventionist should receive a copy of this child's IFSP and evaluations immediately upon assignment to work with the child. It is the joint responsibility of the Service Coordinator and the service agency supervisor to ensure prompt delivery of these documents to the interventionist, and it is the responsibility of the interventionist to follow up with his/her agency supervisor if the documents are not received within two weeks of assignment.

Service Type/Frequency/Duration: ______________________ Therapist's Service Start Date: _____/_____/_____

If there are any gaps in service delivery (i.e., 3 or more consecutively scheduled visits), describe length and reason for gap in service delivery. ____

IFSP OUTCOME(S): ______________________________

RATE OF PROGRESS IN THIS TIME PERIOD

No Progress	Little Progress	Moderate Progress	Great Deal of Progress	Outcome Achieved
☐	☐	☐	☐	☐

How did you work with the family to help the child reach this outcome? ______________________________

IFSP OUTCOME(S): ______________________________

RATE OF PROGRESS IN THIS TIME PERIOD

No Progress	Little Progress	Moderate Progress	Great Deal of Progress	Outcome Achieved
☐	☐	☐	☐	☐

How did you work with the family to help the child reach this outcome? ______________________________

IFSP OUTCOME(S): ______________________________

RATE OF PROGRESS IN THIS TIME PERIOD

No Progress	Little Progress	Moderate Progress	Great Deal of Progress	Outcome Achieved
☐	☐	☐	☐	☐

How did you work with the family to help the child reach this outcome? ______________________________

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(Circle One) 6 month 12 month Amendment Discharge

Child's Name: _____ IFSP Period: From ___/___/___ To ___/___/___
(Last) (First)

1. Provide a description of progress; in addition, please estimate the percentage of delay at the end of the 6 month and 12 month period and state how that was determined, e.g., criterion referenced instrument, developmental checklist, or clinical opinion. (Standard deviation scores or formal evaluations are not required.)

2. List any factors that limit the collaboration between parent and interventionist. How have you addressed these factors? Be specific.

3. How have you used feedback from the family to help you modify how you work with the family? Be specific and provide examples.

4. Recommendations (include here any new IFSP outcomes, or changes in strategies and activities):

I certify that I have received a copy of the child's IFSP (and evaluation if available). I have provided the services described above in accordance with the frequency and duration mandated by IFSP, and have worked toward addressing the relevant outcomes set forth in the IFSP. I further certify that my responses in this report are an accurate representation of the child's current level of functioning.

Signature of Interventionist completing report: _____Date: _____/_____/_____

License #/Certification/Designation _____

Reset Form

PROGRESS NOTE INSTRUCTIONS

Please Note: Effective April 1, 2014, Westchester County EIP has eliminated the requirement for quarterly progress notes.

1. Providers must complete progress notes in preparation for the child's 6 month and Annual IFSP(s). Notes need to be completed and submitted to the child's OSC **three (3) weeks prior** to the expiration of the child's current IFSP period.

2. Progress Notes are also required to be completed:
   - When an interventionist is recommending a change in the current IFSP
   - When an interventionist is recommending a supplemental evaluation
   - Upon discharge from the EIP
   - Upon discharge from an interventionist's caseload
   - Upon request of an EIOD

3. The form should be completed as follows:

PAGE 1 – Interventionist

Circle the appropriate interval for the report.

Child's Name: Make sure that the child's name is the same as the EI record.
IFSP Period: The term of the current IFSP.
DOB: Child's date of birth
Provider Agency Name: Agency for which the interventionist works.
Interventionist: Name of the interventionist who is completing this progress note.
License#/Certification: Indicate license # or if certified write "certified" and do not indicate number
Discipline: Interventionist's discipline, e.g. Speech therapist, Occupational therapist, etc.
Service Type: The service the interventionist is delivering.
Authorization Frequency: How often the service is authorized.
Service Start date: The date on which the interventionist began his or her work with the child.
If gaps in service delivery: Document the extent and the reason.
IFSP Outcomes: The outcomes from the IFSP that have been addressed during the 6 month period. Similar outcomes may be grouped, e.g., outcomes that require similar skills, etc.
Rating: How much progress has been made in achieving the IFSP outcome(s) noted.
How did you work with the family: The techniques and strategies used with the family to achieve the outcome.

Repeat as needed for all outcomes that are applicable to the interventionist completing the form. Use additional sheets as needed

PAGE 2 – Interventionist

Question 1. Describe the child's progress and level of functioning. Estimate the percentage of delay, and describe how you determined it. This can be done based on clinical opinion; the ongoing work and regular informal assessment of the child's needs; and/or the use of a developmental checklist or criterion referenced instrument. Formal evaluations are not necessary. Standard deviation scores may be used, but are not necessary. Age equivalents may be used, if used appropriately.

Question 2. List any issues or factors that have limited the collaboration between the interventionist and those who are an important part of the child's daily life. Describe the steps taken to overcome the particular barriers. Have these strategies been successful, or are new plans needed to help the family become involved?

Question 3. Provide information about the parent/caregiver feedback to the therapist regarding how well the activities worked when the therapist was not present. Were modifications based on this feedback successful, or are further modifications necessary?

Questions 4. Make recommendations for new IFSP outcomes, changes in strategies and activities, and continuation, termination, or change in type of service for the next 6 months. Recommendations for service must be consistent with the need documented in Question #3. Recommendations should include plans for parent/caregiver involvement.

Answer all questions completely.

REVIEW THE ATTESTATION – If, for any reason, the interventionist does not have the child's IFSP, cross out and initial that part of the attestation: "I certify that I have received a copy of the child's IFSP (and evaluation if available)…" Indicate below the attestation what has been done or will be done to obtain a copy of the child's IFSP. No other part of the attestation may be crossed out.

Sign and date the report. Include interventionist's license#/certification.