AzEIP

Where Every Family Has a Team

Quarterly Progress Report

Child's Name: _____ Date of Birth: _____ Date of Report: _____

IFSP Date: _____ Consent on file: ☐ Recipient: _____

Support or Intervention Child is Receiving **TL-Team Lead JV-Joint Visitor**	**Child and Family Outcomes:**
☐ Evaluation/Assessment	
☐ Developmental Special Instruction	
☐ Family Support, Training,	
☐ Occupational Therapy	
☐ Physical Therapy	
☐ Speech-Language Therapy	**Progress since last report:**
☐ Assistive Technology	
☐ Other (Cued language, nutrition, social work, psychological services, orientation & mobility)	
☐ Hearing Specialist	
☐ Vision Specialist	
Recommendations:	

*If you have any questions regarding this report, please review it with the family or contact the individual below.

(Print) _____ (Signature) _____ _____

Team Lead Date

(Print) _____ _____

Service Coordinator Phone No.

[AzEIP Program]

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

DES/AzEIP
3839 N. Third Street, Suite 304
Phoenix, AZ 85012
(602) 532-9960