Interim Services Plan

To establish Head Start/Early Head Start/Child Development Program objectives, goals and environmental modifications based on individual needs and/or current evaluation(s).

Child's Name:_____ **Date:**_____

DOB:_____ **Classroom:**_____

☐ **IEP** ☐ **IFSP** ☐ **Referred** ☐ **Other (circle one)**

Child's Strengths:

Area of Focus:

Describe the steps that will be taken to accomplish the area of focus:

1.

2.

3.

4.

Projected outcome and documented evidence:

Participants – Please Sign & Date

Parent Signature	Date	Teacher /CFS	Date
Coach/PSC Signature	Date	Other	Date

Refer to GOLD objectives for child's next steps of development.