



WCMCA EARLY HEAD START INDIVIDUALIZED TRANSITION ACTION PLAN



Child's Name: _____ DOB: _____ Parent's Name: _____ Start Transition: _____

Early Head Start Area: _____ FES: _____ Transition To: _____

Transition Process	What Parent Will Do	What Staff Will Do	Target Date/ Date Completed	Progress Comments
Review Transition Options: <ul style="list-style-type: none"> • Head Start • Early Childhood Family Education • Private Preschool • Child Care • Other _____ 				
Fill Out appropriate registration for transition options (Head Start Application): <ul style="list-style-type: none"> • Release of Info prior to transfer of Early Head Start records (Physical, Cognitive, Social Emotional) 				
Choose Program Site Location: 1. 2.				
Site Visited: Participants:				
Enrollment/Registration Paperwork Completed to:				
Meet with Early Childhood Special Education Staff and Review plan (if Applicable)				
Conference with Transitioning Program Staff:				
Parent/Guardian notified about acceptance into program by:				

Parent/Guardian Signature: _____ Staff Signature: _____ Transition Completed Date _____