Use your "Mouse" or "Tab" key to move through the fields and check boxes. After completing last field, save document to hard drive to make future updates or click print button.

Illinois State Board of Education

Early Childhood Block Grant (ECBG) Behavior Support Plan

Please complete each section of the Behavior Support Plan. The fields that are required to be entered into the Student Information System (SIS) have been identified in this form.

Educational Entity Information

Community-Based Organization (CBO) or School District Name:	CBO/District RCDT Number

ECBG Type: ☐ Prevention Initiative ☐ Preschool for All ☐ Preschool for All Expansion

Student Information

First/Last Name	Date of Birth	Student Identification Number (SID)

Parent/Guardian Name	Phone	Email

Describe initial and ongoing behavior(s).

Describe ongoing communication with the parents/guardians in a culturally and linguistically appropriate manner.

Date	Family Member/ Guardian Name	Summary of Communication	Method of Communication (e.g., phone call, email, in-person meeting)	Length of Meeting/Call (if applicable)

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Specify attempts made by the program to seek training, technical support, and professional development resources to improve the ability of teachers, administrators, program directors, and other staff per Section 235.320 of the Administrative Code.	
Describe in detail the specific activities and strategies that will be implemented to promote a supportive teacher-child relationship and will support an increase in positive behaviors. Include a timeline for intervention and the use of data to evaluate progress that will be shared with the family/guardian.	
Specific strategies to promote teacher-child relationships:	
Timeline for intervention:	
Data used to evaluate progress:	

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Behavior Support Plan - SIS Data Elements	
Plan Implemented Date	•Must be before the Date Transition Recommended. •Must be after the Enrollment Entry Date. •Must be before or equal to the Enrollment Exit Date.
Transition Recommended	☐ Yes (If Yes, complete the ISBE ECBG Program Transition Plan.) ☐ No
Date Transition Recommended (if applicable)	•Must be after the Plan Implemented Date provided on the Behavior Support Plan. •Must be after the latest Intervention Date provided on the Behavior Support Plan. •Must be after the Enrollment Entry Date. •Must be before or equal to the Enrollment Exit Date.

The signatures below confirm that all parties are in agreement with the Behavior Support Plan.		
Plan Signed by:	Signature	Date
Name of Program Staff Member		
Name of Program Administrator/Center Director		
Name of Parent/Guardian		
Name of Qualified Professional		

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Behavior Support Plan - Intervention Action/SIS Data Elements

Complete the following fields for each intervention. This page may be duplicated to accommodate multiple interventions.
- **At least one date must be provided; multiple dates can be provided.**
- **Must be after the Plan Implemented Date provided for the Behavior Support Plan and before the Plan Implemented Date provided for the Program Transition Plan.**
- **Must be after the Enrollment Entry Date.**
- **Must be before or equal to the Enrollment Exit Date.**

Intervention Date	Intervention Type (Select one)	*Qualified Professional Information (Complete when an Intervention Type with * is selected)	
	☐ Sent to another classroom ☐ Sent to Administrator's office ☐ Administrator was brought into classroom ☐ Developmental Screening* ☐ Referrals to Community Resources* ☐ Referral to Mental Health Consultant* ☐ Referral to Child's Health Care Provider*	**First and Last Name**	**Type of Qualified Professional** ☐ Mental Health Consultant ☐ Licensed Clinical Social Worker ☐ Speech Pathologist ☐ Behavioral Therapist ☐ Health Care Provider
		Number of Contact Hours Program Leaders: Program Staff: Family:	

Intervention Reason (Select one)	Intervention Outcome
☐ Serious safety threat ☐ Challenging behavior	

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