Illinois
State Board of Education

Early Childhood Block Grant (ECBG) Program Transition Plan

The plan must include documentation of the initial and repeated behaviors as well as ongoing communication with parents. The plan also must include the attempts to use community resources.

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).

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Transition Determination – Student Information System (SIS) Data Elements

Reason	Date	
☐ A determination by a qualified professional ☐ The program determined that the current early childhood program does not meet the child's developmental needs ☐ The program's inability to provide the supports needed to maintain the child in the program ☐ The child was withdrawn from the program by the parent/guardian	**Plan Implemented**	• Must be after the Date Transition Recommended provided on the Behavior Support Plan. • Must be before or equal to the Enrollment Exit Date.
	ISBE Notification	• Must be after the Plan Implemented Date provided on the Behavior Support Plan. • Must be before or equal to the Enrollment Exit Date.

Complete Qualified Professional Information below.

First and Last Name		☐ Mental Health Consultant ☐ Licensed Clinical Social Worker ☐ Speech Pathologist ☐ Behavioral Therapist ☐ Health Care Provider
Hours With:		
Program Leaders		
Program Staff		
Family		

Transition Program Information – SIS Data Elements

Transitioned Program Name		Transitioned Date
RCDTS (if applicable)		
DCFS License (if applicable) Alphanumeric up to 10 char.		•Must be after the Plan Implemented Date provided for the Program Transition Plan. •Must be before or equal to the Enrollment Exit Date.

Transitioned Program City (Domestic or International)	State (2-Letter Abbreviation, 00 if International)	ZIP Code (Domestic Only)

Referral Status (if applicable)

☐ Referred to a district for evaluation

☐ Pending evaluation

☐ After evaluation, found eligible for special education services

☐ Referred to Early Intervention (B-3)

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Provide summary of where the child is transitioning.

Provide summary if child did not transition.

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Program Transition Plan - Intervention Action

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)	
		First and Last Name	**Type of Qualified Professional**
	☐ 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*	 **Number of Contact Hours** Program Leaders: Program Staff: Family:	☐ Mental Health Consultant ☐ Licensed Clinical Social Worker ☐ Speech Pathologist ☐ Behavioral Therapist ☐ Health Care Provider

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

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List outside community resources utilized and dates used.		
Outside Community Resource Name	**Community Resource Provided**	**Dates Community Resource Utilized**

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)

The signatures below confirm that all parties are in agreement with the Program Transition 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		