OUTCOME PLAN

Child's Name: Katie **Service:** Transition Plan

Persons Responsible: Sara/Juliann/Carla **Date:** 2-22

Outcome Statement:
What is to be accomplished?

Katie will have family approved services in place by age 3.

Activities:

1. Special Education Coop will be notified and a meeting arranged 90 days prior to Katie's third birthday.
2. Sara and Bill will visit programs under consideration and visit with potential speech language providers.
3. Sara and Bill will determine what, if any, information will be shared with future preschool.
4. Juliann and Carla will provide activities for family to continue developing communication skills.
5. LouAnn will update assessment and complete vision and nutrition re-evaluation before Katie's birthday.
6. Hearing evaluation results will be shared by Alicia.
7. Additional resources for working on communication will be researched.
8. Reports will be sent to Dr. Jones quarterly by LouAnn.

Evaluation:

Parents will determine satisfaction with transition plan in October on a 3 point scale.
3 - Complete satisfaction - activities completed.
2 - Partial satisfaction-revise - only some activities completed.
1 - Limited satisfaction - few, if any, activities completed.

Timelines:

Date began: 2-22 Date completed: _____ Dates for review: 8-22