

Tri-County Head Start/Early Head Start

Family Partnership Goal Statement

Family Name _____ Client's Name _____

FSA _____ Center _____

Family 1st Goal:

Steps and Strategies

1. _____
2. _____
3. _____
4. _____
5. _____

Resources Needed to Meet Goal:

_____ At this time, I (we) choose not to work on any family goals. I understand that we will review this at our next Home Visit /Conference.

Initial Partnership meeting date _____ 1st Goal Met on _____
Staff's first meeting with parent to discuss goal.

Parent/Guardian Signature _____

Goal Work Follow-Up

Mid-Year Follow-Up Date:	Mid-Year Achievement Score:	End of Year Follow-Up Date:	End of Year Achievement Score:
_____ <small>(month) (day) (year)</small>	1 2 3 4	_____ <small>(month) (day) (year)</small>	1 2 3 4

Scoring

1. Goal Achieved
2. Goal Partially (1/2) Achieved
3. Minimal Progress
4. No Progress