



Level 1: Initial Support Plan

Name: _____

Date of Plan: _____

Review Date of Plan: _____

Area of Focus:	
Goal 1:	
Expectation:	
Required Actions:	
Criteria for Success:	
Supports:	

Area of Focus:	
Goal 2:	
Expectation:	
Required Actions:	
Criteria for Success:	
Supports:	

Educator's Signature	Educator's Printed Name
Administrator's Signature	Administrator's Printed Name

Outcome(s) from Level 1 Initial Support	
☐	Significant progress was noted after at least 30 days. No further assistance is required
☐	Some progress was noted after at least 30 days. The teacher will continue on a Level 1 Initial Support Plan.
<i>Date of Review of Progress Toward Growth Target:</i>	
☐	Minimal progress was noted after at least 30 days. The educator will be moved to a Level 2 Targeted Support Plan.