

Child and Family Guidance Center
180 Fairfield Ave, 2nd FL
Bridgeport, CT 06604 – 4252
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Foster Grandparent Program CARE PLAN

Date: _____

Volunteer School/Site: _____

Contact Person: _____

Assigned Child: _____ Age: _____
(Use only First Name or Code)

IDENTIFIED NEED(S): (These needs can be observed or diagnosed)

Language Delay _____ Educationally Disadvantaged _____

Developmental Delay _____ English Proficiency _____

Social/Emotional Adjustment _____ Physically Challenged _____

Other: _____

FOSTER GRANPARENT TASKS:

- 1.
- 2.
- 3.
- 4.

DESIRED RESULTS:

- 1.
- 2.
- 3.
- 4.

(Results should coincide with the tasks)

Foster Grandparent Program _____ Date: _____

Project Director Signature

Volunteer Site/School Representative _____ Date: _____

Signature

Foster Grandparent Volunteer _____ Date: _____

Signature