

Commonwealth of Massachusetts  
Department of Social Services  
Child Care Activity Plan (CCAP)

Valley Opportunity Council Inc.  
300 High Street, 3<sup>rd</sup> Floor  
Holyoke, MA 01040

45 Day     Quarterly

Child's Enrollment Date:

Child's Name:

D.O.B

Started with  
Educator

Plan Date:

Reassess Date:

Parent(s)/Guardian(s) Name:

DCF Social Worker

Transportation

Yes     No

Fees Assessed

Yes     No

ANSWER IN FULL SENTENCE

1). How is the child's self-Control?

-----

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2). Child's Cognitive Development/ How does the child communicate? Does the child express him/herself?

-----

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3). Does the child know their basic colors, shapes and numbers? (What colors? What shapes? How high can He/She count?.

-----

\_\_\_\_\_

\_\_\_\_\_

4). Does the child have a favorite activity? What is the activity?

-----

\_\_\_\_\_

\_\_\_\_\_

5)How is the child's Large Motor Skills? (Walking, Running, Jumping) How is the child's Fine Motor Skills? (Cutting, Puzzles, Beads)

-----

\_\_\_\_\_

\_\_\_\_\_

6). Child's Social Skills/Does the child play well with other children?

-----

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7). How Does the Child Relate to New Experiences?

8). Have you seen Child/Parent/Guardian interaction?

9). Child's Attendance at Program/ Are you notified when child is out?

10). Does the child have any medical problems?

11). List Additional Developmental Services, Agencies Providing Services and Frequency of Services (speech and language, physical and/or occupational therapy, psychological services, other) When Applicable.

12). Additional Comments/Information (provider discretion):

Transitioning

**PLEASE SPECIFY:**

- At six month reassessment, family has been provided with transition counseling re: Eligibility and fee payment requirements, and waitlisting in advance for basic child care.
- Child has been on our waiting list for our basic program (if applicable) on: \_\_\_\_\_ month/day/year

For foster children utilizing FPCC services, this process must occur at initial intake.

\_\_\_\_\_  
Educator/ Staff Signature

\_\_\_\_\_  
Date