Miami-Dade County Public Schools

SST/PST Intervention Plan

Student Information:

Name: ____________________________ ID#: ____________________________________ Date of Meeting: __________________

School: ____________________________ Grade: _________________________________ ESOL Level: _______________________

Parent Notification: Date ________________ Attended: Yes ☐ No ☐

Intervention Plan: Beginning Date: ___________________ Implementing Personnel: __________________________________

READING	Description of Intervention/Strategy	Setting/Where	When will it occur?	Person Responsible
☐ Phonemic Awareness				
☐ Phonics				
☐ Fluency				
☐ Comprehension				
☐ Vocabulary				
☐ Oral Language				

MATH	Description of Intervention/Strategy	Setting/Where	When will it occur?	Person Responsible
☐ Calculation				
☐ Problem Solving				

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Student Name: ______________________________ ID: ______________________________

WRITTEN EXPRESSION	Description of Intervention/Strategy	Setting/Where	When will it occur?	Person Responsible
☐ Composition				

COMMUNICATION	Description of Intervention/Strategy	Setting/Where	When will it occur?	Person Responsible
☐ Articulation				
☐ Expressive Language				
☐ Receptive Language				
☐ Listening Comprehension				

OTHER: *(Considering the hypothesis from the Problem Analysis, what instruction/intervention strategies will be implemented:*

	Description of Intervention/Strategy	Setting/Where	When will it occur?	Person Responsible
☐ ___________				

I. PROGRESS MONITORING PLAN:

	Progress Monitoring Tool	Person Responsible	Dates when it will occur?	Dates of Review?
_________				

II. DOCUMENTATION OF FIDELITY:

	What will be documented	Person Responsible	When will it occur?	Where will it occur?
_________				

PROGRESS GOAL/EXPECTED LEVEL OF PROGRESS

(Student Name)______________________________will improve his/her (area of intervention focus) _____________________ at a rate of _________________ per week/month.

Complete and attach SST/PST Tier 3 Intervention Student Progress Goal and Graph

FOLLOW-UP MEETING DATE: (*Must be scheduled at the initial meeting*)____

SST/PST INTERVENTION PLAN

Student Name: ____ ID: ____

Signatures of Persons Present at Meeting

Teacher: ____ Reading Leader: ____

Teacher: ______________________________ ______________________ Math Leader: ____

Parent/Guardian: ____ FAB Specialist: ____

Parent/Guardian: ____ School Psychologist: ______________________________________

ESL Teacher: ____ Social Worker: ____

Administrator/SST/PST Coordinator: _____________________________ Other: ____

Date SST/PST requests M-Team evaluation: ____________________________________