





**SPECIAL EDUCATION SERVICE GOAL, IF PROVIDED**

Student's Name: \_\_\_\_\_

MEASURABLE ANNUAL GOAL(S)										
BENCHMARK/ SHORT-TERM INSTRUCTIONAL OBJECTIVE(S)	T.A. *	AGENCY RESPONSIBLE**	METHOD(S)	REPORT OF PROGRESS						
				1st	2nd	3rd	4th	5th	6th	
BEGINNING/ENDING DATES OF SERVICES:	FREQUENCY:		PROGRESS TOWARD ANNUAL GOAL:							
LOCATION OF SERVICES:			REASON(S) FOR NOT MEETING GOAL:							

EXPLANATION OF CODING SYSTEM			
<b>METHOD(S) OF MEASUREMENT</b> 1. Written Observation 2. Written Performance 3. Oral Performance 4. Criterion-Referenced Test 5. Time Sample 6. Demonstration/Performance 7. Other (Specify) _____	<b>REPORT OF PROGRESS</b> 1. Not applicable during this grading period 2. No progress made 3. Little progress made 4. Progress made; Objective not yet met 5. Objective met	<b>PROGRESS TOWARD ANNUAL GOAL</b> 1. Anticipate meeting goal 2. Do not anticipate meeting goal (note reason) 3. Goal met (indicate date)	<b>REASON FOR NOT MEETING GOAL</b> 1. More time needed 2. Excessive absences/tardies 3. Assignments not completed 4. Need to review/revise IEP 5. Other (Specify) _____ _____ _____

\* Check if objective is a transition activity. (students ages 14 – 20)

\*\* Designate agency responsible for assistance with implementation of objective. (students ages 16 - 20)

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V - 5

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<b>METHOD(S) OF MEASUREMENT</b> 1. Written Observation 2. Written Performance 3. Oral Performance 4. Criterion-Referenced Test 5. Time Sample 6. Demonstration/Performance 7. Other (Specify) _____	<b>REPORT OF PROGRESS</b> 1. Not applicable during this grading period 2. No progress made 3. Little progress made 4. Progress made; Objective not yet met 5. Objective met	<b>PROGRESS TOWARD ANNUAL GOAL</b> 1. Anticipate meeting goal  2. Do not anticipate meeting goal (note reason)  3. Goal met (indicate date)	<b>REASON FOR NOT MEETING GOAL</b> 1. More time needed 2. Excessive absences/tardies 3. Assignments not completed 4. Need to review/revise IEP 5. Other (Specify) _____ _____

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 \*\* Designate agency responsible for assistance with implementation of objective. (students ages 16 - 20)

9-6

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V-7





RELATED SERVICES, IF PROVIDED				
SERVICE	BEGINNING/ENDING DATE	LOCATION	AMOUNT OF TIME	FREQUENCY

<p><b>METHOD OF INFORMING PARENTS OF PROGRESS</b></p> <p>Notification of progress toward meeting annual goals will be through the use of :</p> <p>Notification will be given:</p> <p><input type="checkbox"/> Every six weeks      <input type="checkbox"/> Every nine weeks</p> <p><input type="checkbox"/> Other (specify) _____</p>	<p><b>WRITTEN PARENTAL PERMISSION FOR INITIAL PLACEMENT</b></p> <p>My rights and those of my child regarding procedural safeguards have been fully explained; I understand that my child has a disability and I know what that disability is; and I hereby give consent for my child to receive special education services based on his/her eligibility determination and his/her individualized educational program.</p> <p>Parental Signature _____ Date _____</p>
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EXTENDED SCHOOL YEAR (ESY) SERVICES, IF PROVIDED							
_____ Criteria Met for ESY services		_____ Criteria not met for ESY services			_____ Decision deferred until _____		
MAINTAINED SPECIAL EDUCATION SKILLS	NUMBER OF WEEKS	NUMBER OF DAYS PER WEEK	AMOUNT OF TIME PER DAY	MAINTAINED RELATED SERVICE SKILLS	NUMBER OF WEEKS	NUMBER OF DAYS PER WEEK	AMOUNT OF TIME PER DAY

<p><b>COMMITTEE MEMBERS PRESENT</b></p> <p><small>(Does not require signatures; this section is utilized only to document individuals present at the meeting)</small></p> <p>Name: _____ Special Education Teacher</p> <p>Name: _____ Regular Education Teacher</p> <p>Name: _____ Agency Representative</p> <p>Name: _____ Parent(s)</p> <p>Name: _____ Student, If Applicable</p> <p>Name: _____ Other</p> <p>Name: _____ Other</p> <p>Name: _____ Other</p> <p>Date of Meeting: _____</p> <p>Projected Date of Review/Revision of IEP: _____</p>	<p><b>IEP REVIEW/REVISION – COMMITTEE MEMBERS PRESENT</b></p> <p><small>(Does not require signatures; this section is utilized only to document individuals present at the meeting)</small></p> <p>Name: _____ Special Education Teacher</p> <p>Name: _____ Regular Education Teacher</p> <p>Name: _____ Agency Representative</p> <p>Name: _____ Parent(s)</p> <p>Name: _____ Student, If Applicable</p> <p>Name: _____ Other</p> <p>Name: _____ Other</p> <p>Name: _____ Other</p> <p>Date of Meeting: _____</p>
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**INDIVIDUAL TRANSITION PLAN, IF PROVIDED**

**BY AGE 14: DESIRED POST-SCHOOL OUTCOME STATEMENT:** This statement should address areas of post-school activities such as post-secondary education, vocational training, integrated employment, continuing and adult education, adult services, independent living and/or community participation.

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**BY AGE 16: TRANSITION SERVICES STATEMENT:**

SERVICE AREA(S)	NEEDED		PUBLIC AGENCY RESPONSIBILITIES FOR LINKAGES TO SERVICES	
	YES	NO	PUBLIC AGENCY	SPECIFIC RESPONSIBILITIES FOR LINKAGES BY PUBLIC AGENCY
Instruction				
Related Services				
Community Experiences				
Adult Living/Employment Skills				
(Complete only when appropriate) Daily Living Skills/Functional Vocational Evaluation				