

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

School Year: _____

Public Agency/School District: _____

Student's Name: _____

IEP Committee Meeting Date: _____ / _____ / 20
Month Day YearIEP Implementation Date (Projected Date when Services and Programs Will Begin): _____ / _____ / 20
Day Year Month Day Year ProjectedEnd Date: _____ / _____ / 20 Projected Date of Annual Review: _____ / _____ / 20
Month Day Year Month Day YearStudent's Name: _____ Date of Birth: _____ / _____ / _____ Age: _____
Month Day YearEthnicity: _____ Gender: Female Male

Primary Eligibility Category: _____ Secondary Eligibility Category: _____

Current Eligibility Date: _____ / _____ / 20 Projected Reevaluation Date: _____ / _____ / 20
Month Day Year Month Day Year

MSIS Number: _____ Grade: _____ School: _____

Parent/Guardian Name: _____ Phone Number: _____

Address: _____ Email: _____

IEP COMMITTEE PARTICIPANTS *(Signatures are not required.)* Initial [*Written Parental Permission For Initial Placement must be signed before implementation*] Annual

Name	Position	Name	Position

Names and Position of Excused IEP Committee Members

An IEP Committee member may be excused in whole or in part, if the parent and/or adult student and public agency agree in writing prior to the IEP meeting. If the meeting deals with the excused member's areas, he or she will provide written input to the IEP Committee prior to the meeting. **Attach all written documentation to the IEP.**

The IEP meeting was conducted via alternate means of technology: N/A
 Video Conferencing Conference Call Other: _____

This IEP meeting was recorded:
 Yes No

EVALUATIONS

Indicate plans to conduct a Functional Behavioral Assessment (FBA), evaluation for Assistive Technology, or other evaluation(s)/follow-up(s) to determine special education and/or related service needs.

WRITTEN PARENTAL PERMISSION FOR INITIAL PLACEMENT *(Sign only after the IEP has been reviewed)*

My rights and those of my child as outlined in the Procedural Safeguards Notice have been fully explained to me. I understand that my child has a disability, and I know my child's eligibility category. I hereby give consent for my child to receive special education services as recorded on this Individualized Education Program (IEP).

Parent/Guardian Signature: _____ Date: _____

PROCEDURAL SAFEGUARDS NOTICE

I have received a copy of the Procedural Safeguards Notice, and my rights and those of my child have been fully explained. The public agency has informed me of whom I may contact if I need additional information.

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

School Year: _____

Public Agency/School District: _____

Student's Name: _____

Parent/Guardian Signature: _____ Date: _____

IEP COMMITTEE PARTICIPANTS (Signatures are not required.)IEP Action: Review Revise Amend ESY Date: ____/____/20____

Name	Position	Name	Position
	Agency Representative		Other: _____
	General Educator		Other: _____
	Special Educator		Other: _____
	Parent/Guardian		Other: _____
	Parent/Guardian		Other: _____
	Student		Other: _____

Names and Position of Excused IEP Committee Members

An IEP Committee member may be excused in whole or in part, if the parent and/or adult student and public agency agree in writing prior to the IEP meeting. If the meeting deals with the excused member's areas, he or she will provide written input to the IEP Committee prior to the meeting. **Attach all written documentation to the IEP.**

The IEP meeting was conducted via alternate means of technology: N/A
 Video Conferencing Conference Call Other: _____

This IEP meeting was recorded:
 Yes No

EVALUATIONS

Indicate plans to conduct a Functional Behavioral Assessment (FBA), evaluation for Assistive Technology, or other evaluation(s)/follow-up(s) to determine special education and/or related service needs.

PROCEDURAL SAFEGUARDS NOTICE

- I have received a copy of the Procedural Safeguards Notice, and my rights and those of my child have been fully explained. The public agency has informed me of whom I may contact if I need additional information.
- I do not wish to receive a copy of the Procedural Safeguards Notice. The public agency has informed me of whom I may contact if I need additional information.

Parent/Guardian Signature: _____ Date: _____

SUMMARY OF REVISION

Describe any changes in services and supports in the IEP (e.g., addition or deletion of services provided, increase or decrease in frequency of services provided).

Check to verify that all changes were made in the IEP.

PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

Student's Strengths, Preferences, and Interests

Identify the student's educational and/or developmental strengths, interest areas, significant personal attributes and personal accomplishments as indicated by formal or informal assessment. Identify the skills or behaviors the student has mastered. Be sure to include specific feedback from the student. If 14 years of age or older, describe the student's strengths, preference and interests related to their postsecondary expectations (education, employment/training and daily living if appropriate).

List data sources relative to describing the student's strengths, preferences and interests (e.g. interviews, formal assessments, informal assessments etc.).

Impact of Disability and Student Needs (Critical Skills and Behaviors or Developmentally Appropriate Activities)

Describe the effects of the student's disability on involvement and progress in the general education curriculum, including the impact on the student's current level of functioning in reading and math and the functional implications of the student's skills. For a preschool student, describe the effect of this student's disability on involvement in developmentally appropriate activities. If 14 years of age or older, describe the effect of this student's disability on the pursuit of postsecondary expectations (education, employment/training and daily living if appropriate).

List data sources relative to describing the student's needs and impact of his/her disability (e.g. progress monitoring, observations, assessments, etc.).

Parent/Student Input

Include any concerns of the parent and, as appropriate, the student for enhancing his or her education.

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

School Year: _____

Ages 3-5

Public Agency/School District: _____

Student's Name: _____

PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE		
Present Levels of Social Emotional Skills and Relationships Performance Summary:		
<input type="checkbox"/> Social <input type="checkbox"/> Emotional <input type="checkbox"/> Behavioral <input type="checkbox"/> Other: _____		
Present Levels of Knowledge and Skills Performance Summary:		
<input type="checkbox"/> Communication <input type="checkbox"/> Pre-Academic <input type="checkbox"/> Cognitive <input type="checkbox"/> Other: _____		
Present Levels of Appropriate Behavior to Meet Needs Performance Summary:		
<input type="checkbox"/> Gross/Fine Motor Skills <input type="checkbox"/> Adaptive/Daily Living Skills <input type="checkbox"/> Other: _____		
<p style="text-align: center;"><i>Include (a) a clear description of the observable "target" skill or behavior, (b) the condition under which the target skill or behavior can be observed and (c) the <u>current</u> rate of performance based on baseline data.</i></p>		
Does this area impact the student's social emotional skills and relationships performance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this area impact the student's knowledge and skills performance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does this area impact the student's appropriate behavior to meet needs performance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEASURABLE ANNUAL GOAL		
Goal #	Measurable Annual Goal	MOM
Obj. #	Short-Term Instructional Objectives/Benchmarks (STIO/B)	
1		
2		
3		
4		
5		
Report of Progress		
Methods of Measurement (MOM)	Progress on Annual Goal (PAG)	
OBS = Observation CRT = Criterion-Referenced Test CBM = Curriculum-Based Measure WS = Work Samples D/P = Demonstration/Performance Other: _____	A. The student is making sufficient progress to meet the annual goal. B. The student is making insufficient progress to meet the annual goal. (An IEP meeting must be held to discuss revisions.) C. The annual goal has been met or exceeded. D. This annual goal has not been introduced yet.	
Date of Report	Current Level of Performance (CLP) for Report of Progress	PAG
	<i>Describe the student's current performance on the annual goal based on progress on STIO/Bs using the identified method(s) of measurement (OBS, CRT, CBM, WS, D/P, etc.).</i>	
Notification of Progress Provided to Parents/Guardians		
Type	<input type="checkbox"/> Progress Notes <input type="checkbox"/> Report Cards <input type="checkbox"/> Goals Sheets <input type="checkbox"/> Other: _____	
Frequency	<input type="checkbox"/> Every 4 ½ weeks <input type="checkbox"/> Every 6 weeks <input type="checkbox"/> Every 9 Weeks <input type="checkbox"/> Other: _____	

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

School Year: _____

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Student's Name: _____

PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

Present Levels of Academic Performance Summary: Reading Math

Present Levels of Functional Performance Summary: Communication Social Emotional Behavioral
 Gross/Fine Motor Skills Career and Technical Education and Employment Adaptive/Daily Living Skills
 Other: _____

Include (a) a clear description of the observable "target" skill or behavior, (b) the condition under which the target skill or behavior can be observed and (c) the current rate of performance based on baseline data.

Does this area impact the student's academic achievement?

Yes No

Does this area impact the student's functional performance?

Yes No

MEASURABLE ANNUAL GOAL

Goal #	Measurable Annual Goal	TA*	MOM
Obj. #	Short-Term Instructional Objectives/Benchmarks (STIO/B)		
1			
2			
3			
4			
5			

Report of Progress

Methods of Measurement (MOM)	Progress on Annual Goal (PAG)
OBS = Observation CRT = Criterion-Referenced Test CBM = Curriculum-Based Measure WS = Work Samples D/P = Demonstration/Performance Other: _____	A. The student is making sufficient progress to meet the annual goal. B. The student is making insufficient progress to meet the annual goal. (An IEP meeting must be held to discuss revisions.) C. The annual goal has been met or exceeded. D. This annual goal has not been introduced yet.

Date of Report	Current Level of Performance (CLP) for Report of Progress <i>Describe the student's current performance on the annual goal based on progress on STIO/Bs using the identified method(s) of measurement (OBS, CRT, CBM, WS, D/P, etc.).</i>	PAG

Notification of Progress Provided to Parents/Guardians

Type	<input type="checkbox"/> Progress Notes <input type="checkbox"/> Report Cards <input type="checkbox"/> Goals Sheets <input type="checkbox"/> Other: _____
Frequency	<input type="checkbox"/> Every 4 ½ weeks <input type="checkbox"/> Every 6 weeks <input type="checkbox"/> Every 9 Weeks <input type="checkbox"/> Other: _____

*TA = Transition Activity

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

School Year: _____

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Student's Name: _____

SPECIAL CONSIDERATIONS***Communication (Required)**Does the student have special communication needs? Yes No**Document the basis for the decision:****Assistive Technology (Required)**Does the student need assistive technology services or devices to maintain or improve functional capabilities? Yes NoDoes the student need assistive technology assessment? Yes No**Document the basis for the decision:****Service for Students who are Blind or Visually Impaired** N/A*In the case of a student who is blind or visually impaired, provide for instruction in and the use of Braille unless the IEP Committee determines, after an evaluation of the student's reading and writing media, Braille instruction is not appropriate.*Instruction in Braille considered? Yes No

Evaluation Date: _____

Is instruction in Braille appropriate? Yes No**Document the basis for the decision:**Were the parents provided information about the Mississippi School for the Blind? Yes No**Service for Students who are Deaf or Hearing Impaired** N/A*In the case of the student who is deaf or hearing impaired, consider language and communication needs, opportunities for direct communication needs, academic level, and full range of needs, including direct instruction in the student's language and communication mode.*

Student's language and communication mode: _____

Is direct instruction in the student's language and communication mode needed? Yes No**Document the basis for the decision:**Were the parents provided information regarding the Mississippi School for the Deaf? Yes No**Behavior Intervention** N/A*In the case of a student whose behavior impedes the student's learning or the learning of other students, consideration **must** be given to the use of positive behavior interventions, supports, and other strategies to address that behavior.*1. Has the IEP Committee developed goals and interventions to address specific behavior concerns? Yes No2. Has a Functional Behavioral Assessment (FBA) been conducted? Yes No Date Completed: _____

3. Has a Behavior Intervention Plan (BIP) based on a Functional Behavioral Assessment been developed? **

 Yes No Date developed: _____ Implementation Date: _____ Review / Revised Dates: _____**Document the basis for the decision:*****If a student has a BIP, s/he must have a corresponding annual goal(s) to address behavioral concerns.***Services for Students with Limited English Proficiency** N/A*In the case of a student with limited English Proficiency, consideration is given to the language needs of the student as such needs relate to the student's IEP.***Describe the specific needs and document the basis for the decision:**

* Indicate Special Considerations in the PLAAFP.

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SPECIAL EDUCATION AND RELATED SERVICES					
Special Education					
Service	Area	Location	Start Date	Duration/Frequency	End Date
<i>Document basis for the decision:</i>					
Instructional/Functional Accommodations					
Service	Area	Location	Start Date	Duration/Frequency	End Date
<i>Document basis for the decision:</i>					
Program Modifications					
Service	Area	Location	Start Date	Duration/Frequency	End Date
<i>Document basis for the decision:</i>					
Related Services					
Service	Area	Location	Start Date	Duration/Frequency	End Date
<i>Document basis for the decision:</i>					
Supports for Personnel					
Service	Area	Location	Start Date	Duration/Frequency	End Date
<i>Document basis for the decision:</i>					
Area					
a. Reading	f. Science	k. Music	p. Title I	t. Other: _____	
b. Spelling	g. Health	l. Art	q. Tech Prep	u. Other: _____	
c. English	h. Lunch	m. Computer Science	r. Vocational	v. Other: _____	
d. Math	i. PE	n. Clubs	s. Library	w. Other: _____	
e. Social Studies	j. Guidance/Counseling	o. Recreation Activities		x. Other: _____	

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PARTICIPATION IN STATE-WIDE ASSESSMENT PROGRAM

- This student is not required to participate in State-wide assessments as she or he is over 18 years of age.
- This student meets the criteria for SCD and is under 8 years of age.

Significant Cognitive Disability (SCD) Determination

To be classified as a student having a significant cognitive disability, ALL of the criteria below must be true.

<input type="checkbox"/> Yes <input type="checkbox"/> No	The student demonstrates significant cognitive deficits and poor adaptive skill levels (as determined by that student's comprehensive evaluation) that prevent participation in the standard academic curriculum or achievement of the academic content standards, even with accommodations and modifications.
<input type="checkbox"/> Yes <input type="checkbox"/> No	The student requires extensive direct instruction in both academic and functional skills in multiple settings to accomplish the application and transfer of those skills.
<input type="checkbox"/> Yes <input type="checkbox"/> No	The student's inability to complete the standard academic curriculum is neither the result of excessive or extended absences nor is primarily the result of visual, auditory, or physical disabilities, emotional-behavioral disabilities, specific learning disabilities or social, cultural, or economic differences.

- The student **MEETS** the criteria for having a significant cognitive disability.
- The student **DOES NOT MEET** the criteria for having a significant cognitive disability.

For students classified as having an SCD, indicate the standards in which the student is instructed.

- This student meets the criteria for SCD and receives all instruction on alternate academic achievement standards.
- This student meets the criteria for SCD and receives instruction on grade-level standards in the following content area(s): _____

Indicate the assessment(s) in which the Student will participate (State- or district-wide assessments): *Students may participate in the standard **Grade Level/Subject Area Mississippi Assessment Program**, or the **Grade Level/Subject Area Mississippi Academic Assessment Program-Alternate**. Refer to **Testing Students with Disabilities Regulations** to determine appropriate assessments.*

State- or District-Wide Assessments for Students with a Significant Cognitive Disability

*Assessments for children who meet the criteria for significant cognitive disabilities and receive instruction on alternate academic achievement standards include the **Mississippi Academic Assessment Program – Alternate (MAAP-A)**, **English Language Proficiency Test (ELPT)**, and/or additional tests. .*

Indicate any assessments the student will complete during the current year:	Grade Level (Age for non-graded students)											
	For non-graded students (coded 56, 58, 72, 74 or 78), peer grades are based on the student's age as of September 1 st of the applicable school year											
	PK	K-2	3	4	5	6	7	8	9	10	11	12
	(5-7 yrs)	(8 yrs)	(9 yrs)	(10 yrs)	(11 yrs)	(12 yrs)	(13 yrs)	(14 yrs)	(15 yrs)	(16 yrs)	(17/18 yrs)	
MAAP-A (ELA)												
MAAP-A (Math)												
MAAP-A (Science)												
English Language Proficiency Test (ELPT)												
Other: _____												

ACKNOWLEDGEMENT OF REQUIREMENTS FOR PARTICIPATION IN HIGH SCHOOL SUBJECT AREA TESTS

I have had the Mississippi Statewide Assessment System fully explained to me. I understand that all students will be assessed in some way but only those students who meet the graduation requirements under State Board Policy, Chapter 36, Rule 36.4 and 36.5 will be eligible to receive a traditional high school diploma.

Parent/Guardian Signature: _____ **Date:** _____

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

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PARTICIPATION IN STATE-WIDE ASSESSMENT PROGRAM

State- or District-Wide Assessments for Students without a Significant Cognitive Disability

*Assessments for students who receive instruction on grade-level standards include the **Mississippi Pre K-3 Assessment Support System (MKAS²)**, **Mississippi Academic Assessment Program**, **Mississippi Academic Assessment Program -End-of-Course (MAAP-EOC)**, **Mississippi Career Planning and Assessment System, 2nd Edition (MS-CPAS2)**, **American College Test (ACT)**, **English Language Proficiency Test (ELPT)**, and/or additional tests.*

Indicate any assessments the student will complete during the current year, specifying the edition, if applicable.

	Grade Level												
	PK	K-2	3	4	5	6	7	8	9	10	11	12	
MKAS ² / Kindergarten Readiness Assessment													
MKAS ² /3 rd Grade Summative Assessment													
MAAP (English Language Arts/Literacy)													
MAAP (Mathematics)													
MAAP (Science)													
MAAP-EOC (Algebra I)													
MAAP-EOC (Biology I)													
MAAP-EOC (English II)													
MAAP-EOC (US History)													
MS-CPAS2													
ACT													
English Language Proficiency Test (ELPT)													
Other: _____													

ACKNOWLEDGEMENT OF REQUIREMENTS FOR PARTICIPATION IN THE MKAS²/ 3RD GRADE SUMMATIVE ASSESSMENT

I understand that if my child does not meet the minimum cut score on the Mississippi Academic Assessment Program (English Language Arts), he/she will be required to participate in the alternative 3rd Grade Summative Assessment.

Parent/Guardian Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF REQUIREMENTS FOR PARTICIPATION IN HIGH SCHOOL SUBJECT AREA TESTS

I have had the Mississippi Statewide Assessment System fully explained to me. I understand that all students will be assessed in some way but only students who meet the graduation requirements under State Board Policy Chapter 36, Rule 36.4 and 36.5 will be eligible to receive a traditional high school diploma.

Parent/Guardian Signature: _____ **Date:** _____

STATE-WIDE / DISTRICT-WIDE TEST ACCESSIBILITY / ACCOMMODATIONS

Refer to the current Mississippi Testing Accommodations Manual, and/or American College Test (ACT) Accommodations for Students with Disabilities for information regarding testing accommodations. All accommodations used for State-wide testing must also be used during the student's classroom instruction and assessments.

Presentation Accommodations	Code	Test(s)

Document the basis for the decision:

Response Accommodations	Code	Test(s)

Document the basis for the decision:

Timing and Scheduling Accommodations	Code	Test(s)

Document the basis for the decision:

Setting Accommodations	Code	Test(s)

Document the basis for the decision:

Test

- | | | |
|--|--------------------------|-----------------|
| a. MKAS2/Kindergarten Readiness | g. MAAP-A (Math) | n. ACT |
| b. MKAS2/3 rd Grade Reading Summative | h. MAAP-A (Science) | o. MS-CPAS2 |
| c. MAAP (ELA) | i. ELPT | p. Other: _____ |
| d. MAAP (Math) | j. MAAP-EOC (Algebra I) | q. Other: _____ |
| e. MAAP (Science) | k. MAAP-EOC (Biology I) | r. Other: _____ |
| f. MAAP-A (ELA) | l. MAAP-EOC (English II) | |
| | m. MAAP-EOC (US History) | |

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INDIVIDUAL TRANSITION PLAN

Beginning at age 14, or younger if appropriate, a Transition Plan must be completed with consideration of the student's needs, preferences, and interests. This plan must be updated annually.

Postsecondary Goals

*Specify appropriate measurable postsecondary goals as identified by the student, parent(s) and IEP Committee. Postsecondary goals are based upon **age-appropriate transition assessments** related to employment, education and/or training, and, where appropriate, independent living skills.*

Related IEP Goal(s) #

Education/Training (Required)	
Employment (Required)	
Independent Living (If Appropriate)	

Age-Appropriate Transition Assessments

Transition Assessment (including student and family survey or interview)	Assessment Type	Responsible Agency/Person	Date Conducted	Report Attached
Education/Training (Required)				
Employment (Required)				
Independent Living (If Appropriate)				

Transition Services

*Transition services may include **instruction, related services, community experiences, development of employment and other post-school adult living objectives, and acquisition of daily living skills** to be provided before graduation to support the student in achieving his/her postsecondary goals.*

Instruction (e.g. accommodations, tutoring, skills training, prep for college exam)

List the activities the school, student, parent and any outside agency(ies) will do to help the student reach the stated post-secondary goal(s). Specify any outside agency(ies) that will provide transition services.

Related Services (e.g., parent(s), technology, transportation, medical services, supported services)

List the activities the school, student, parent and any outside agency(ies) will do to help the student reach the stated post-secondary goal(s). Specify any outside agency(ies) that will provide transition services.

Community Experiences (e.g., job shadowing, supported employment, banking, shopping, touring postsecondary institutions)

List the activities the school, student, parent and any outside agency(ies) will do to help the student reach the stated post-secondary goal(s). Specify any outside agency(ies) that will provide transition services.

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

School Year: _____

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Development Of Employment Objectives and Functional Vocational Evaluation (e.g., career planning, guidance counseling, job and career interests, aptitudes and skills)

List the activities the school, student, parent and any outside agency(ies) will do to help the student reach the stated post-secondary goal(s). Specify any outside agency(ies) that will provide transition services.

Acquisition Of Daily Living Skills and Other Post-School Adult Living Objectives (e.g., self-care, home repair, health and safety, money management, registering to vote, adult benefits planning, independent living)

List the activities the school, student, parent and any outside agency(ies) will do to help the student reach the stated post-secondary goal(s). Specify any outside agency(ies) that will provide transition services.

Exit Options

Exit options must be reviewed with the parent and the student, as appropriate, before completing this section

The exit option determined appropriate for the student is:

- Traditional Diploma**
- Career and Technical Endorsement
- Academic Endorsement
- Distinguished Academic Endorsement

- High School Equivalency**

- Mississippi Alternate Diploma**

This option is only available to students that meet the criteria for Significant Cognitive Disability

- Mississippi Occupational Diploma**

This option is only available to students that entered 9th grade prior to the 2017-2018 SY

- Certificate of Completion**

I understand that my child will only be considered for a Traditional High School diploma if he/she meets the graduation requirements under State Board Policy, Chapter 36, Rule 36.4 and 36.5. I also understand that if my child participates in the Mississippi Academic Assessment Program – Alternate (MAAP-A), he/she is being instructed on the Alternate Academic Achievement Standards and will not be considered for a Traditional High School Diploma.

Parent/Guardian Signature

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Course Of Study		
<i>Select the course of study that supports the Student's postsecondary goal(s):</i>		
<input type="checkbox"/> Agriculture, Food and Natural Resources <input type="checkbox"/> Architecture and Construction <input type="checkbox"/> Arts, Media, and Communications <input type="checkbox"/> Business Management and Administration	<input type="checkbox"/> Education and Training <input type="checkbox"/> Finance <input type="checkbox"/> Government and Public Administration <input type="checkbox"/> Health Science <input type="checkbox"/> Hospitality and Tourism <input type="checkbox"/> Human Services <input type="checkbox"/> Information Technology	<input type="checkbox"/> Law, Public Safety, and Security <input type="checkbox"/> Manufacturing <input type="checkbox"/> Marketing <input type="checkbox"/> Science, Technology, Engineering and Mathematics <input type="checkbox"/> Transportation, Distribution, and Logistics
<i>Additional options (SCD only):</i> <input type="checkbox"/> Supported Employment <input type="checkbox"/> Daily Living Activities <input type="checkbox"/> Customized Employment		
<i>List the general and special education class(es) in the student's course of study for the previous, current, and projected year selected on the basis of the student's strengths, interests, preferences and desired postsecondary goals.</i>		
Previous Year's Class(es)	Current Year's Class(es)	Projected Year's Class(es)
Student's Invitation to the IEP Committee Meeting		
The student was invited to the IEP meeting. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Interagency Linkages (Participating Agencies)		
<i>List any agencies/person(s) (a) currently involved with the student or family, (b) who can provide needed information to the IEP Committee and/or (c) likely to become involved in providing support or services after the student exits high school and transitions to the community, employment and/or postsecondary education/training. Written parental consent must be obtained before inviting any agency/person(s) likely to be responsible for providing/paying for transition services.</i>		
<input type="checkbox"/> Education/Training: 	<input type="checkbox"/> Employment: 	<input type="checkbox"/> Independent Living:
TRANSFER OF RIGHTS		
I have been informed of my rights under Part B of the Individuals with Disabilities Education Improvement Act (IDEA) of 2004, as amended, that will transfer to me when I reach the age of majority (21 years of age).		
Student's Signature: _____		Date: _____

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PLACEMENT CONSIDERATIONS AND LEAST RESTRICTIVE ENVIRONMENT (LRE) DETERMINATIONS**Placement Option(s) Considered**

Describe the placement option(s) the IEP Committee considered including any potentially harmful effects each option may have on the student or the quality of services to be provided. Include the level of support required for each placement option.

Document the basis for decision:

Non-Participation with Non-Disabled Peers

Describe the extent to which the student does not participate with his/her non-disabled peers.

Document the basis for decision:

Special Transportation

Is special transportation needed in the selected LRE? Yes No

Document the basis for the decision:

Percentage of Time Student Receives Special Education Outside of the General Education Classroom**Preschool LRE Classification** *(Check one below for Students ages 3-5)*

- | | |
|---|---|
| <input type="checkbox"/> PC /Home | <input type="checkbox"/> PI /Regular program ten (10) or more hours per week and served in the regular program |
| <input type="checkbox"/> PE /Residential Facility | <input type="checkbox"/> PJ /Regular program ten (10) or more hours per week and served in another location |
| <input type="checkbox"/> PF /Separate School | <input type="checkbox"/> PK /Regular program less than ten (10) hours per week and served in the regular program |
| <input type="checkbox"/> PG /Separate Class | <input type="checkbox"/> PL /Regular program less than ten (10) hours per week and served in another location |
| <input type="checkbox"/> PH /Service Provider Location | |

School Age LRE Classification *(Check one below for Students ages 6-21)*

- SA**/Inside general education class 80% or more of the day
- SB**/Inside general education class 40 to 79% of the day
- SC**/Inside general education class less than 40% of the day
- SD**/Separate School
- SF**/Residential Facility
- SH**/Home-Hospital
- SI**/Correctional Facilities
- SJ**/Parentally Placed in Private Schools

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

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EXTENDED SCHOOL YEAR (ESY)

This student attends a twelve (12) month program.

Determination of ESY Decision

Determination Date: _____

*All of the following criteria used in determining eligibility **must** be considered:*

Regression-Recoupment: Refers to a student's loss of a skill on IEP objective(s) after at least two (2) breaks in instruction without regaining the documented level of skill(s) prior to the break within the specified period.

Critical Point of Instruction 1: Refers to the need to maintain a student's critical skill to prevent a loss of general education class time or an increase in special education service time.

Critical Point of Instruction 2: Refers to a point in the acquisition or maintenance of a critical skill during which a length break in instruction would lead to a significant loss of progress.

Extenuating Circumstances: Refers to special situations that jeopardize the student's receipt of a FAPE unless ESY services are provided.

Consideration: The IEP Committee considered all criteria when determining the student's eligibility for receiving ESY services

NOTE: Although ESY services typically focus on existing annual goals or STIO/Bs, the IEP Committee may determine the child needs to master a new goal or objective to be able to master or maintain the critical skill identified as the basis for ESY services. Only in this situation may the IEP Committee write a new goal and/or objective to address this critical skill.

- This student's situation **MEETS** criteria for ESY Services based on _____.
(Indicate criterion that qualified student)
- This student's situation **MEETS** criteria for ESY Services, but the parent/guardian does not accept the service.
- This student's situation **DOES NOT MEET** the criteria for ESY Services.

Document the basis for the decision. Documentation of how the decision was made *MUST* be in the student's file.

Measurable Annual Goals or Short-Term Instructional Objectives/Benchmarks (STIO/B) <i>These must be existing measurable annual goals or STIO/Bs except for situations as described in the note above.</i>	TA	MOM	Report of Progress	
			CLP	PAG

TA = Transition Activity	Methods of Measurement (MOM)		Report of Progress	
	OBS = Observation CRT = Criterion Reference Test CBM = Curriculum Based Measure	WS = Work Samples D/P = Demonstration/Performance Other: _____	CLP = Current Level of Performance PAG = Progress on Annual Goal <i>See Annual Goal page for codes</i>	

A **Progress Report** will be given to parents every _____ week(s) or at the end of the student's ESY services on _____.

Date(s) progress report given to parent _____

Types of Service	# of Weeks	Duration/Frequency	Area <i>(See Special Education and Related Service page for code)</i>	Location	Start Date	End Date
Educational Services						
Related Services**						
Transportation						
Other: _____						
Other: _____						

** Any related services provided (except transportation) **must** have a corresponding measurable annual goal or STIO/B.