



Montana  
Office of Public Instruction  
Denise Juneau, State Superintendent

# Individualized Education Program

|                   |                              |            |     |               |                         |              |
|-------------------|------------------------------|------------|-----|---------------|-------------------------|--------------|
| Student Name      | Initials                     | Birth Date | Age | Gender<br>M F | Grade                   | Today's Date |
| District / School | Last Reevaluation            |            |     |               |                         |              |
|                   | IEP Manager and Phone Number |            |     |               |                         |              |
| Parent(s)' Name   | Parent(s)' Address           |            |     |               | Home Phone              |              |
|                   | E-mail                       |            |     |               | Work Phone / Cell Phone |              |

**Optional Child Count Information:** Disability Category: Race and Ethnicity:

## STRENGTHS, EDUCATIONAL CONCERNS AND PREFERENCES/INTERESTS

### Strengths, Preferences and Interests - Student's Perspective

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Student Strengths

Parents: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

School Staff: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Educational Concerns

Parents: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

School Staff: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## CONSIDERATION OF SPECIAL FACTORS

|  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| • Does the student's behavior impede his/her learning or that of others? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Does the student have communication needs?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| • Does the student require assistive technology devices or services?     | <input type="checkbox"/> | <input type="checkbox"/> |
| • Has the student been determined to be "Limited English Proficient"?    | <input type="checkbox"/> | <input type="checkbox"/> |

**Any item above checked "Yes" must be addressed in the IEP.**

**For a student with blindness or visual impairment** ☐ N/A

|  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| • Does the student need training in orientation and mobility?<br><b>If "Yes" is checked</b> , training must be addressed in the IEP.   | <input type="checkbox"/> | <input type="checkbox"/> |
| • Does the student need instruction in Braille or the use of Braille?<br><b>If "No" is checked</b> , describe in the notes why instruction in Braille or the use of Braille is not appropriate. This decision must be based on evaluation results. | <input type="checkbox"/> | <input type="checkbox"/> |

Student Name: \_\_\_\_\_

IEP Date: \_\_\_\_\_

## TRANSITION SERVICES

For **ALL** students beginning with the IEP to be in effect when the child is 16 and updated annually thereafter.

### STUDENT'S DESIRED POST-SCHOOL ACTIVITIES:

(In the areas of postsecondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living or community participation)

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### RESULTS OF AGE-APPROPRIATE TRANSITION ASSESSMENTS:

( ☐ Results Attached)

EDUCATION: \_\_\_\_\_

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EMPLOYMENT: \_\_\_\_\_

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TRAINING: \_\_\_\_\_

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INDEPENDENT LIVING SKILLS (if appropriate): \_\_\_\_\_

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## MEASURABLE POSTSECONDARY GOALS

Measurable postsecondary goals are based on age-appropriate transition assessments related to training, education, employment, and, if appropriate, independent living skills. Clearly specify the desired level of achievement.

Measurable Postsecondary Goal(s) – Education or Training:

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Measurable Postsecondary Goal(s) – Employment:

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Measurable Postsecondary Goal(s) – Independent Living Skills (if appropriate):

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## TRANSFER OF RIGHTS AT AGE OF MAJORITY

The student has been informed of his or her rights under IDEA that will transfer to the student on reaching the age of majority. The student must be informed at least one year before the student reaches age 18.

Date student was first informed of the transfer of rights: \_\_\_\_\_

Date student reaches the age of majority: \_\_\_\_\_

Student Name: \_\_\_\_\_ IEP Date: \_\_\_\_\_

- Describe below a coordinated set of activities designed within a results-oriented process to:
- focus on improving the academic and functional achievement of the student;
  - directly relate to the student's measurable postsecondary goals and the student's strengths, preferences and interests; and
  - promote movement from school to post-school settings and activities.

**Courses of study needed to assist the student in reaching her or his goal(s):**

Anticipated Graduation Date: \_\_\_\_\_ Credits earned to date: \_\_\_\_\_

Total number of credits required for graduation: \_\_\_\_\_

| School Year       | Credit      | School Year       | Credit      |
|-------------------|-------------|-------------------|-------------|
| _____/_____/_____ | _____/_____ | _____/_____/_____ | _____/_____ |
| _____/_____/_____ | _____/_____ | _____/_____/_____ | _____/_____ |
| _____/_____/_____ | _____/_____ | _____/_____/_____ | _____/_____ |
| _____/_____/_____ | _____/_____ | _____/_____/_____ | _____/_____ |
| _____/_____/_____ | _____/_____ | _____/_____/_____ | _____/_____ |
| _____/_____/_____ | _____/_____ | _____/_____/_____ | _____/_____ |
| _____/_____/_____ | _____/_____ | _____/_____/_____ | _____/_____ |
| TOTAL _____/_____ |             | TOTAL _____/_____ |             |

| TRANSITION SERVICE AREA              | TRANSITION SERVICES NEEDED TO ASSIST THE STUDENT IN MEETING POSTSECONDARY GOALS<br>(include timeline for achievement) | PERSON OR AGENCY RESPONSIBLE | ANNUAL GOAL #<br>(if necessary) |
|--------------------------------------|---|------------------------------|---------------------------------|
| INSTRUCTION                          | <input type="checkbox"/> Discussed and not needed   |                              |                                 |
| EMPLOYMENT                           | <input type="checkbox"/> Discussed and not needed   |                              |                                 |
| COMMUNITY EXPERIENCES                | <input type="checkbox"/> Discussed and not needed   |                              |                                 |
| POST-SCHOOL ADULT LIVING             | <input type="checkbox"/> Discussed and not needed   |                              |                                 |
| RELATED SERVICES                     | <input type="checkbox"/> Discussed and not needed   |                              |                                 |
| DAILY LIVING SKILLS (IF APPROPRIATE) | <input type="checkbox"/> Discussed and not needed   |                              |                                 |
| FUNCTIONAL VOCATIONAL ASSESSMENT     | <input type="checkbox"/> Discussed and not needed   |                              |                                 |

Student Name: \_\_\_\_\_

IEP Date: \_\_\_\_\_

**OUTCOME MEASURES FOR 3, 4, 5 AND 6-YEAR-OLD CHILDREN***Do not complete this page if this is an INITIAL IEP for a 6-year-old student.*

The IEP team must rate the child's present level of functional performance in the three areas below. Based on assessment, rate the child's performance in each area on a scale of 1-7 (whole numbers only). For students leaving preschool services, also note whether the child has shown new skills or behaviors since the last assessment.

**Check the assessment procedure(s) used to draw these conclusions:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Academic      | <input type="checkbox"/> Behavioral       | <input type="checkbox"/> Class-based Assessment    |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Developmental    | <input type="checkbox"/> Observations              |
| <input type="checkbox"/> Psychological | <input type="checkbox"/> Social/Emotional | <input type="checkbox"/> Other (Describe in NOTES) |

| PRESENT LEVEL OF FUNCTIONAL PERFORMANCE  | RATING   |
|--|--|
| Positive Social-Emotional, including Social Relationships  |  |
| Acquisition and Use of Knowledge and Skills, including Early Language, Communication and Early Literacy  |  |
| Use of Appropriate Behaviors to Meet Individual Needs  |  |
| RATING DESCRIPTIONS  |  |
| Child shows functioning expected for his or her age in all or almost all everyday situations that are part of the child's life. Functioning is considered appropriate for his or her age. There are no concerns about the child's functioning in this area.  | <b>7</b>   |
| Child shows functioning generally considered appropriate for his or her age, but there are some concerns about the child's functioning in this area.   | <b>6</b>   |
| Child shows functioning expected for his or her age some of the time and/or in some situations. Child's functioning is a mix of age-appropriate and not age-appropriate functioning. Functioning can be described as like that of a slightly younger child.  | <b>5</b>   |
| Child shows some, but not much, age-appropriate functioning.   | <b>4</b>   |
| Child does not yet show functioning expected of a child of his or her age in any situation. Child's behaviors and skills include immediate foundational skills upon which to build age-appropriate functioning. Functioning might be described as like that of a younger child.                          | <b>3</b>   |
| Child's behaviors and skills include some immediate foundational skills, but these are not displayed very often across settings and situations.  | <b>2</b>   |
| Child does not yet show functioning expected of a child his or her age in any situation. Child's skills and behaviors do not yet include any immediate foundational skills upon which to build age-appropriate functioning. Child's functioning might be described as like that of a much younger child. | <b>1</b>   |
| <b>Leaving Preschool ONLY: Has the child shown any new skills or behaviors since the assessment?</b>   |  |
| Positive Social-Emotional Skills, including Social Relationships:  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Acquisition and Use of Knowledge and Skills, including Early Language, Communication and Early Literacy:   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Use of Appropriate Behaviors to Meet Individual Needs:   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Student Name: \_\_\_\_\_ IEP Date: \_\_\_\_\_

## PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE AND MEASURABLE ANNUAL GOALS

**Special Education/Related Service Area:** \_\_\_\_\_

Describe the academic, developmental and functional strengths and needs of the student and how the disability affects involvement and progress in the general curriculum or, for preschool children, involvement in appropriate activities. Test scores alone are insufficient.

**Present Levels of Academic Achievement and Functional Performance:**

Describe academic and functional goals to meet the student's identified needs and enable the student to be involved in and make progress in the general education curriculum. Clearly specify the desired level of achievement.

**Measurable Annual Goal (# \_\_\_\_\_):**

Mark here if the Measurable Annual Goal will be part of an Extended School Year service: ☐

| <b>Date of Progress Report:</b> |  |  |  |  |  |  |  |  |
|---------------------------------|--|--|--|--|--|--|--|--|
| Goal not yet started            |  |  |  |  |  |  |  |  |
| Not expected to meet goal       |  |  |  |  |  |  |  |  |
| Expected to meet goal           |  |  |  |  |  |  |  |  |
| Met goal                        |  |  |  |  |  |  |  |  |

Describe academic and functional goals to meet the student's identified needs and enable the student to be involved in and make progress in the general education curriculum. Clearly specify the desired level of achievement.

**Measurable Annual Goal (# \_\_\_\_\_):**

Mark here if the Measurable Annual Goal will be part of an Extended School Year service: ☐

| <b>Date of Progress Report:</b> |  |  |  |  |  |  |  |  |
|---------------------------------|--|--|--|--|--|--|--|--|
| Goal not yet started            |  |  |  |  |  |  |  |  |
| Not expected to meet goal       |  |  |  |  |  |  |  |  |
| Expected to meet goal           |  |  |  |  |  |  |  |  |
| Met goal                        |  |  |  |  |  |  |  |  |

When will progress reports on the measurable annual goal be provided to the parents?

☐ quarterly ☐ semester ☐ other: \_\_\_\_\_

Student Name: \_\_\_\_\_ IEP Date: \_\_\_\_\_

**PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE, MEASURABLE ANNUAL GOALS AND BENCHMARKS OR SHORT-TERM OBJECTIVES**

**Special Education/Related Service Area:** \_\_\_\_\_

Describe the academic, developmental and functional strengths and needs of the student and how the disability affects involvement and progress in the general education curriculum or, for preschool-aged children, involvement in appropriate activities. Test scores alone are insufficient.

**Present Levels of Academic Achievement and Functional Performance:**

Describe academic and functional goals to meet the student's identified needs and enable the student to be involved in and make progress in the general education curriculum. Clearly specify the desired level of achievement.

**Measurable Annual Goal (# \_\_\_\_\_):**

|                                 |  |  |  |  |  |  |  |  |
|---------------------------------|--|--|--|--|--|--|--|--|
| <b>Date of Progress Report:</b> |  |  |  |  |  |  |  |  |
| Goal not yet started            |  |  |  |  |  |  |  |  |
| Not expected to meet goal       |  |  |  |  |  |  |  |  |
| Expected to meet goal           |  |  |  |  |  |  |  |  |
| Met goal                        |  |  |  |  |  |  |  |  |

**Benchmarks or Short-Term Objectives:**

(Mark ☒ only if the benchmark or short-term objective will be part of an Extended School Year service.)

|  |                          |
|--|--------------------------|
|  | <b>ESY</b>               |
|  | <input type="checkbox"/> |
|  | <input type="checkbox"/> |
|  | <input type="checkbox"/> |
|  | <input type="checkbox"/> |

When will progress reports on the measurable annual goal be provided to the parents?

☐ quarterly    ☐ semester    ☐ other:

|   |   |  |  |   |
|---|---|--|--|---|
| Student Name: _____   |   |  | IEP Date: _____  |   |
| <b>SPECIAL EDUCATION AND RELATED SERVICES</b>   |   |  |  |   |
| Special Education or Related Service Area   | Hours per week in Special Education Setting | Special Education Hours per week in General Education Setting  | Total hours per week   | Dates of service (if different from annual IEP dates) |
|   |   |  |  |   |
|   |   |  |  |   |
|   |   |  |  |   |
|   |   |  |  |   |
|   |   |  |  |   |
|   |   |  |  |   |
| <b>Total Hours:</b>   |   |  |  |   |
| <b>PARTICIPATION IN THE REGULAR EDUCATION PROGRAM</b>   |   |  |  |   |
| <b>Students ages 6 and above</b><br><input type="checkbox"/> Regular Class<br><i>(In the regular education class at least 80% or more of the day)</i><br><input type="checkbox"/> Part-time Special Education<br><i>(In the regular education class between 40% and 79% of the day)</i><br><input type="checkbox"/> Full-time Special Education<br><i>(In the regular education class less than 40% of the day)</i><br><input type="checkbox"/> Separate Day School (public or private)<br><input type="checkbox"/> Residential Facility (public or private)<br><input type="checkbox"/> Homebound/Hospital |   | <b>Students ages 3-5</b><br>Early Childhood Setting means a program outside the child's home that includes at least 50% children without disabilities. Examples: Head Start, Kindergarten, Private preschool, group child care.<br><input type="checkbox"/> Early Childhood Setting (at least 80% of the time.)<br><input type="checkbox"/> Early Childhood Setting (40% to 79% of the time)<br><input type="checkbox"/> Early Childhood Setting (less than 40% of the time)<br><input type="checkbox"/> Special Education Setting - Separate Class (less than 50% children without disabilities)<br><input type="checkbox"/> Separate Day School (public or private day schools designed specifically for children with disabilities)<br><input type="checkbox"/> Residential Facility (public or private)<br><input type="checkbox"/> Home<br><input type="checkbox"/> Service provider location (received all special education and related services from a service provider, and did not attend other program) |  |   |
| <b>LEAST RESTRICTIVE ENVIRONMENT</b>  |   |  |  |   |
| A student with a disability shall not be removed from education in age-appropriate regular classrooms solely because of needed modifications in the general education curriculum.   |   |  |  |   |
| <ul style="list-style-type: none"> <li>• The educational placement is based on the student's IEP.</li> <li>• The educational placement is as close as possible to the student's home.</li> <li>• The educational placement is in the school that the student would attend if he or she did not have a disability.</li> <li>• The IEP team considered any potential harmful effect of the educational placement on the student or on the quality of needed services.</li> </ul>  |   |  | <input type="checkbox"/> YES <input type="checkbox"/> NO<br><input type="checkbox"/> YES <input type="checkbox"/> NO<br><input type="checkbox"/> YES <input type="checkbox"/> NO<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| <b>If "No" is checked</b> , explain why. _____<br>_____<br>If the student's school day or week is shorter or longer than peers without disabilities, explain why.<br>_____<br>_____   |   |  |  |   |

Student Name: \_\_\_\_\_ IEP Date: \_\_\_\_\_

### SUPPLEMENTARY AIDS AND SERVICES

Regular education classes, other education-related settings, and extracurricular and nonacademic settings, where accommodations/modifications are needed.

Specific accommodations, modifications, supplementary aids and services, assistive technology or other forms of support to enable children with disabilities to be educated with children without disabilities. Include program modifications or supports for teachers, related service providers, transportation providers and others working with this student. ☐ **None Needed**

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

### PARTICIPATION IN STATE/DISTRICTWIDE ASSESSMENTS

The student will participate in the **State/Districtwide** assessments in the following manner: (Check one box for each test.)

**CRT Tests (Grades 3-8, 10)** ☐ N/A

- ☐ Without accommodations  
☐ With accommodation(s)  
☐ CRT-Alternate\*

**Districtwide Tests** ☐ N/A

- ☐ Without accommodations  
☐ With accommodation(s)  
☐ Alternate Assessment

Identify any test accommodations that must be provided for the student:

CRT: \_\_\_\_\_

Districtwide: \_\_\_\_\_

For any student who participates in an alternate assessment describe:

Why the child cannot participate in the regular assessment, and;

\_\_\_\_\_

Why the particular alternate assessment selected is appropriate for the child.

\_\_\_\_\_

\* The student may not participate in the CRT-Alternate unless the student's demonstrated cognitive abilities and adaptive behavior require substantial adjustments to the regular curriculum; learning objectives and expected outcomes focus on functional application, as shown by the IEP's goals/objectives; and the student requires direct and extensive instruction to acquire, maintain, regularize and transfer skills.

**For students who participate in the CRT-Alternate, the student's IEP must contain benchmarks or short-term objectives.**

### EXTENDED SCHOOL YEAR

- ☐ Extended School Year services **are necessary** for the student.
- ☐ Extended School Year services **are not necessary** for the student.
- ☐ Determination of need for Extended School Year services will be made by: \_\_\_\_\_ (date)



Student Name: \_\_\_\_\_ IEP DATE: \_\_\_\_\_

### NEED FOR REEVALUATION TO DETERMINE ELIGIBILITY

- ☐ The parent and the school district agree that a reevaluation **is unnecessary** at this time to determine whether the student continues to have a disability and needs special education.
- ☐ A reevaluation **is necessary** to determine whether the student continues to have a disability and needs special education.

Reevaluations must occur at least once every three years, unless the parent and the school district agree that a reevaluation is unnecessary.

### IEP ACCESSIBILITY AND RESPONSIBILITIES

**How** will each teacher, related service provider, transportation provider and others working with this student be informed of his or her specific responsibilities for implementing this IEP and the accommodations, modifications, and supports that must be provided for this student?

- ☐ Copy of Accommodations/Modifications handout    ☐ E-mail    ☐ Verbal communication
- ☐ Other: \_\_\_\_\_

### DOCUMENTATION OF PARTICIPATION

The following persons, as indicated by their signatures, have participated in the development of this IEP:

|   |               |   |               |
|---|---------------|---|---------------|
| _____<br><b>Parent</b>                    | _____<br>Date | _____<br><b>Parent</b>                      | _____<br>Date |
| _____<br><b>Student</b>                   | _____<br>Date | _____<br><b>Speech/Language Pathologist</b> | _____<br>Date |
| _____<br><b>Administrator or Designee</b> | _____<br>Date | _____<br><b>Signature/Position</b>          | _____<br>Date |
| _____<br><b>Regular Education Teacher</b> | _____<br>Date | _____<br><b>Signature/Position</b>          | _____<br>Date |
| _____<br><b>Special Education Teacher</b> | _____<br>Date | _____<br><b>Signature/Position</b>          | _____<br>Date |

I have read and understand my rights as provided to me in the pamphlet PROCEDURAL SAFEGUARDS IN SPECIAL EDUCATION UNDER IDEA, which I received this school year. The parent shall be given a copy of this IEP at no cost to the parent.

- ☐ I approve of this Individualized Education Program.
- ☐ I approve of this Individualized Education Program with the following exceptions\*: \_\_\_\_\_

\_\_\_\_\_  
Parent/Adult Student

\_\_\_\_\_  
Date

\*The IEP team agrees to meet again on \_\_\_\_\_ to resolve differences regarding the above exceptions.  
date

## IEP NOTES

Student Name: \_\_\_\_\_

IEP Date: \_\_\_\_\_

For Informational  
Purposes Only

For Informational  
Purposes Only