

Individualized Education Program (IEP) - TRANSITION

State of Delaware

School District

302-

Student Name:	
Student ID#:	D.O.B.:
Address:	
City:	State:
Zip:	Current Grade:
District of residence:	
Attending Building:	

Disability Classification:

Parent 1:	<input type="checkbox"/> P	<input type="checkbox"/> S	<input type="checkbox"/> G
Address (if different):			
Phone (H):	(W):		
Cell:	Email:		
Parent 2:	<input type="checkbox"/> P	<input type="checkbox"/> S	<input type="checkbox"/> G
Address (if different):			
Phone (H):	(W):		
Cell:	Email:		

P S G – check if parent, surrogate, or guardian

IEP Status

Meeting Date		Most Recent Evaluation Summary Report Date	
IEP Initiation Date		IEP Revision Date	
IEP End Date		IEP Revision Date	

Unless revised, this IEP is in effect for the school year including those students eligible for longer school years because of disability classification.

Temporary Placement	
Agency Representative:	
Parent:	
Date:	
Within 60 days, an IEP meeting must be held.	

Meeting Participants

Role	Print Name	Signature
Parent 1		
Parent 2		
Student		
General Ed. Teacher		
Special Ed. Teacher		
Administrator / Designee		

Data Considerations

1. What are the student's strengths?	
	Employment Strengths:
	Post-Secondary Education/Training Strengths:
	Independent Living Strengths:
2. What are the educational concerns of the parent (or student, if appropriate)?	
3. What multiple data sources (including district or statewide assessments) are being used to create this IEP? <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <input type="checkbox"/> Survey/Questionnaires <input type="checkbox"/> Profiles/Portfolios <input type="checkbox"/> Vocational Assessments </div> <div style="margin-top: 5px;"><input type="checkbox"/> Other:</div>	
4. How are extracurricular and non-academic areas affected by the student's disability?	

Other Factors to Consider:

IEP team must consider each of the factors.

If there is a need identified, check "yes" and address in the IEP.

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Communication needs of the student
<input type="checkbox"/>	<input type="checkbox"/>	Braille instruction for students who are blind or visually impaired
<input type="checkbox"/>	<input type="checkbox"/>	Communication and language needs for students who are deaf/hard of hearing
<input type="checkbox"/>	<input type="checkbox"/>	Language needs for students with limited English proficiency
<input type="checkbox"/>	<input type="checkbox"/>	Positive behavior interventions, supports, and strategies for students whose behavior impedes learning
<input type="checkbox"/>	<input type="checkbox"/>	Need for assistive technology devices or services

Name: _____ Date: _____

Student's Post-High School Goals:

Post School Employment Goal	
Post Education/Training	
Independent Living (if needed)	

The student plans to exit school with: ☐ Diploma ☐ Certificate

Courses of Study:

Grade	Courses of Study (from student's current year to year of graduation)

Activities and Services to reach goal:

Employment Goal:				
Activities/Services needed to reach goal	Responsible Party		Start Date	Completion Date

Post-Secondary Education/Training Goal:				
Activities/Services needed to reach goal	Responsible Party		Start Date	Completion Date

Independent Living Goal (if needed):				
Activities/Services needed to reach goal	Responsible Party		Start Date	Completion Date

In addition to School Supports, the Student Will Need the Assistance of:

Agency	Contact Person	Phone Number

Name: _____ Date: _____

Is there a current Interagency Release of Information Form on file with the school?

☐ Yes ☐ No (If no, discuss form for transition planning with appropriate agencies)

Name: _____ Date: _____

IEP team must consider each of the following when determining the needs to be addressed within this IEP:

- How is the student progressing in the general education curriculum (on grade-level)?
- How does the child's disability affect progress in the general education curriculum?
- What are the child's other educational needs that result from the child's disability (e.g., organizational skills, self care, fine/gross motor)?

Unique Educational Needs and Characteristics	A statement of the special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable, to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel.

Services, Aids & Modifications	Start Date	Frequency	Duration	Location

Name: _____ Date: _____

PLEP (Present Level of Educational Performance):					
Benchmark #1	1st Marking Period	Progress	[m]	[y]	
					<input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> N
Narrative (Benchmark #1):					
Benchmark #2	1st Marking Period	Progress	[m]	[y]	
					<input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> N
Narrative (Benchmark #2):					
Benchmark #3	1st Marking Period	Progress	[m]	[y]	
					<input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> N
Narrative (Benchmark #3):					
Benchmark #4	1st Marking Period	Progress	[m]	[y]	
					<input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> N
Narrative (Benchmark #4):					
Annual Goal: <div style="height: 80px; border: 1px solid black; margin-top: 5px;"></div>					

M – mastered annual goal
 S – sufficient progress to meet annual goal
 N – not sufficient progress to meet annual goal

Therapist Signature: _____ Date: _____ (For Medicaid Cost Recovery)

Name: _____ Date: _____

Transportation

Special transportation needs? If yes, specify:	YES <input type="checkbox"/>	NO <input type="checkbox"/>
It is necessary to place this student, who is transported from the school by bus into the charge of a parent or other authorized responsible person. Transportation Department will be notified by:	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Participation in Statewide Assessment

<input type="checkbox"/>	Student will participate in regular testing conditions without accommodations unless one of the below is checked.
<input type="checkbox"/>	Student participates with accommodations as documented on the attached Student Accommodation Checklist.
<input type="checkbox"/>	Student is included in Alternate Assessment. The Participation Guidelines form is attached and #64 is filled in on the Student Accommodation Checklist.

Discipline

The student will adhere to School Code of Conduct. (Check below if any of the following are needed):	
<input type="checkbox"/>	Interventions and supports are described under services/supports and/or in goals.
<input type="checkbox"/>	Behavior intervention and support plan (see attached).
<input type="checkbox"/>	Other:

Consideration of Eligibility for Extended School Year Services (ESY)

IEP team must consider each of the following factors:		
• Regression / Recoupment	• Vocational Skills	• Degree of Impairment
• Breakthrough Skills	• Extenuating Circumstances	
Is ESY needed?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> To Be Determined
<input type="checkbox"/> ESY offered, but declined by parent		
Rationale for decision:		
Specify goals and services:		
<input type="checkbox"/> See attached page (if needed)		

Name: _____ Date: _____

Least Restrictive Environment/Placement

Use the option below to determine the appropriate setting.		
<input type="checkbox"/>	A.	Regular Setting Includes pull-out related services and team classrooms. Student served inside the regular classroom greater than or equal to 80% of the day.
<input type="checkbox"/>	B.	Services Provided Both in Separate Special Education Classes and Regular Setting Student served inside the regular classroom greater than or equal to 40% of the day and no more than 79% of the day.
<input type="checkbox"/>	C.	Separate Special Education in an Integrated Setting Student served inside the regular classroom less than 40% of the day.
<input type="checkbox"/>	D.	Separate School Student served in public or private separate day school facility for greater than 50% of the school day or a residential facility if student does not live at the facility.
<input type="checkbox"/>	E.	Residential Facility where student resides during the school week.
<input type="checkbox"/>	F.	Homebound or Hospital
<input type="checkbox"/>	G.	Correctional Facilities (only used by DSCYF and Prison Education) Students placed in short-term detention or correctional facilities.
Explain why the option selected is the most appropriate as the least restrictive environment. If a setting other than A is chosen, describe the other options considered and provide reasons these options were not selected.		

Student Parent Signatures

<input type="checkbox"/> Yes	<input type="checkbox"/> No	I acknowledge that I have received a copy of the Procedural Safeguards. My due process rights under those Procedural Safeguards have been explained to me.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	I agree with the program described in this document.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	I agree with the placement decision as noted above and discussed at this meeting.
<input type="checkbox"/> Yes	<input type="checkbox"/> N/A	At least one year before the age of majority (18), student has been informed that rights will transfer to him/her unless a legal guardian has been appointed.

Parent/Guardian/Surrogate/Student Signature

Date

Parent/Guardian/Surrogate/Student Signature

Date

If Parent Does Not Attend

Staff member below is responsible for forwarding a copy of the IEP and Procedural Safeguards and explaining content, if necessary to the Parent.

Name

Position

Method of Contact