INDIVIDUALIZED EDUCATION PROGRAM (IEP)

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Effective July 1, 2007)

○ Draft
○ Approved
○ Amended ____________________

Student Information

Name: Agency: IEP Team Meeting Date: / /

STUDENT AND SCHOOL INFORMATION

First Name:____________________ MI: ___ Last Name:____________________

Address: ____________________

City: ____________________State: _____ Zip Code:____________

Grade:______________

Unique Student Identification Number (State): ____________________

Student Identification Number (local): ____________________

Date of Birth: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

Age:________ Gender: ○ MALE ○ FEMALE

Race:
- ☐ American Indian or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ Black or African American (not Hispanic)
- ☐ Hispanic or Latino
- ☐ White (not Hispanic)

Student identified as Limited English Proficient: ○ YES ○ NO

Student's native language: ____________________

Residence County: ____________________

Residence School: ____________________

Service County: ____________________

Service School:____________________

Which jurisdiction is financially responsible? ____________________

Is the student currently under the care and custody of a state agency? ○ YES ○ NO

If yes, name of state agency: ____________________

Does the student require a parent surrogate? ○ YES ○ NO

Parent Surrogate Name: ________________ Surrogate Phone: ____________

PARENT/GUARDIAN 1

First Name:____________________ MI: ___ Last Name:____________________

Home Phone: (____) ______-__________Cell: (____) ______-__________

Email: ____________________

Parent native language, if not English: ____________________

Interpreter needed? ○ YES ○ NO

PARENT/GUARDIAN 2

First Name:____________________ MI: ___ Last Name:____________________

Home Phone: (____) ______-__________Cell: (____) ______-__________

Email: ____________________

Parent native language, if not English: ____________________

Interpreter needed? ○ YES ○ NO

Case Manager: ____________________

IEP Team Meeting Date(s): ____________________

IEP Annual Review Date: ____________________

○ Parent was provided a copy of the *Procedural Safeguards Parental Rights* document.

Projected Annual Review Date: ____________________

Most Recent Evaluation Date: ____________________

Projected Evaluation Date: ____________________

Primary Disability: ____________________

Areas affected by disability: ____________________

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EXIT INFORMATION

Exit date: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

Exit category:
- ○ A - Returned to general education
- ○ B - Graduated with a Maryland High School Diploma
- ○ C - Received Maryland High School Certificate of Program Completion
- ○ D - Reached 21 years of age
- ○ E - Deceased
- ○ F - Moved, known to be continuing
- ○ H - Dropped Out
- ○ I - Special Case

IEP TEAM PARTICIPANTS

IEP Case Manager: ____________________

IEP Chair: ____________________

Parent/Guardian:____________________

Parent/Guardian:____________________

Principal/Designee:____________________

General Educator: ____________________

Special Educator:____________________

Guidance Counselor: ____________________

School Psychologist: ____________________

Social Worker: ____________________

Speech/Language Pathologist:______________

Student: ____________________

Agency Representative: ________________

Others in attendance:________________

Others in attendance:________________

Others in attendance:________________

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

I. MEETING AND IDENTIFYING INFORMATION

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Effective July 1, 2007)

Name: Agency: IEP Team Meeting Date: / /

INITIAL EVALUATION ELIGIBILITY DATA (Only required for student's initial evaluation to determine eligibility)

Identify area(s) impacted by the student's suspected disability: ____________________

Discussion to support decision: ____________________

Is a determinant factor for the student's lack of academic progress the result of:

a) a lack of appropriate instruction in reading, including essential components of reading instruction? ○ YES ○ NO

b) lack of instruction in math? ○ YES ○ NO

c) limited English proficiency? ○ YES ○ NO (If yes to any of the above, the student is not eligible for special education.)

Does the student require specially designed instruction in order to make adequate progress in school? ○ YES ○ NO

Eligible as a student with a disability? ○ Yes ○ No Document basis for decision(s): ____________________

Indicate primary disability

○ AUTISM	○ DEVELOPMENTAL DELAY	○ MENTAL RETARDATION	○ SPECIFIC LEARNING DISABILITY	○ VISUAL IMPAIRMENT
○ DEAF	○ EMOTIONAL DISTURBANCE	○ ORTHOPEDIC IMPAIRMENT	○ SPEECH OR LANGUAGE IMPAIRMENT	○ MULTIPLE DISABILITIES
○ DEAF - BLINDNESS	○ HEARING IMPAIRMENT	○ OTHER HEALTH IMPAIRMENT	○ TRAUMATIC BRAIN INJURY	Cognitive: ☐ Autism ☐ Mental Retardation ☐ Traumatic Brain Injury Sensory/Physical: ☐ Deaf ☐ Deaf-Blindness ☐ Orthopedic Impairment ☐ Visual Impairment

Date of parent consent for initial evaluation: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)
Date of initial evaluation: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)
Date of initial IEP development: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)
Date of parent consent for initiation of services: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)
Date of implementation of initial IEP: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

Reason(s) for delay: ○ Student not available ○ Parent requested delay ○ Other, explain ____________________

If the parent fails to respond or refuses consent to the initial provision of special education and related services, the public agency shall not provide special education and related services to the student and will not be considered in violation of the requirement to make FAPE available in accordance with 34 CFR §300.

Is this student transitioning from Infants and Toddlers (Part C) to Preschool (Part B) and will be receiving services? ○ YES ○ NO

CONTINUED ELIGIBILITY DATA (Required for reevaluation at least once every three years)

Specify the area(s) identified for reevaluation: ____________________

Discussion to support decision: ____________________

Evaluation Date: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY) (This is the most recent date on which the IEP team completed a full and comprehensive review of all assessment materials.)

Does the student continue to have a disability and such educational needs that require the continued provision of special education and related services? ○ YES ○ NO

Are any additions or modifications to special education and related services needed to enable the student to meet the measurable annual goals set out in the student's IEP and to participate, as appropriate, in the general education curriculum? ○ YES ○ NO

Eligible as a student with a disability? ○ Yes ○ No Document basis for decision(s): ____________________

Indicate primary disability

○ AUTISM	○ DEVELOPMENTAL DELAY	○ MENTAL RETARDATION	○ SPECIFIC LEARNING DISABILITY	○ VISUAL IMPAIRMENT
○ DEAF	○ EMOTIONAL DISTURBANCE	○ ORTHOPEDIC IMPAIRMENT	○ SPEECH OR LANGUAGE IMPAIRMENT	○ MULTIPLE DISABILITIES
○ DEAF - BLINDNESS	○ HEARING IMPAIRMENT	○ OTHER HEALTH IMPAIRMENT	○ TRAUMATIC BRAIN INJURY	Cognitive: ☐ Autism ☐ Mental Retardation ☐ Traumatic Brain Injury Sensory/Physical: ☐ Deaf ☐ Deaf-Blindness ☐ Orthopedic Impairment ☐ Visual Impairment

STUDENT PARTICIPATION ON DISTRICT/STATEWIDE ASSESSMENTS AND GRADUATION INFORMATION

Graduation requirements explained to parents? ◯ YES ◯ NO

Will the student participate in the Maryland School Assessment aligned with grade level academic achievement standards in assessed grade? (MSA)
Reading ◯ YES ◯ NO Math ◯ YES ◯ NO Science ◯ YES ◯ NO

Will the student participate in the Modified Maryland School Assessment aligned with modified academic achievement standards in assessed grade? (Mod-MSA)
Reading ◯ YES ◯ NO Math ◯ YES ◯ NO Science ◯ YES ◯ NO

Will the student participate in the Maryland High School Assessment aligned with course content standards in assessed grade? (HSA)
English ◯ YES ◯ NO Algebra/Data Analysis ◯ YES ◯ NO Biology ◯ YES ◯ NO
Government ◯ YES ◯ NO

Will the student participate in the Maryland High School Assessment aligned with modified course content standards in assessed grade? (Mod-HSA)
English ◯ YES ◯ NO Algebra/Data Analysis ◯ YES ◯ NO Biology ◯ YES ◯ NO

Is the student to participate in Alternate Maryland School Assessment aligned with alternate academic achievement standards in reading, math and science? (Alt-MSA)
◯ YES ◯ NO

Document basis for decision(s): ____

____

Student is pursuing a:

◯ Maryland High School Diploma ◯ Maryland High School Certificate of Program Completion

State graduation requirements can be found at www.marylandpublicschools.org.

Also record any additional local school system graduation requirements:

____

____

____

What was the student's performance on the Maryland Model for School Readiness (MMSR) Kindergarten Assessment?

☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

◯ FULL ◯ APPROACHING ◯ DEVELOPING

What was the student's performance on the Language Assessment Scale (LAS) Links?

Assessment Date ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

Score ____________________

◯ FULLY PROFICIENT ◯ LIMITED PROFICIENCY ◯ NOT PROFICIENT

Is the student limited English proficient? ◯ YES ◯ NO

What was the student's performance on MSA? ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

MSA Assessments	Scale Score (Check Mod, if appropriate.)			
Reading ☐ Mod		◯ BASIC	◯ PROFICIENT	◯ ADVANCED
Math ☐ Mod		◯ BASIC	◯ PROFICIENT	◯ ADVANCED
Science ☐ Mod		◯ BASIC	◯ PROFICIENT	◯ ADVANCED

What was the student's performance on HSA? ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

HSA Assessments (Check Mod, if appropriate.)	Passing Score	Minimum Score	Student's Score	Meets Standard
English ☐ Mod	396	386		◯ YES ◯ NO
Algebra/ Data Analysis ☐ Mod	412	402		◯ YES ◯ NO
Government	394	387		◯ YES ◯ NO
Biology ☐ Mod	400	391		◯ YES ◯ NO
Composite Score				◯ YES ◯ NO

What was the student's performance on Alt-MSA? ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

Alt-MSA Assessments	% of Mastery Objectives			
Reading		◯ BASIC	◯ PROFICIENT	◯ ADVANCED
Math		◯ BASIC	◯ PROFICIENT	◯ ADVANCED
Science		◯ BASIC	◯ PROFICIENT	◯ ADVANCED

Name: Agency: IEP Team Meeting Date: / /

ACADEMIC ____________________

Document student's academic achievement and functional performance levels in academic areas, as appropriate.

Source(s): ____________________

Instructional Grade Level Performance: ____________________

(Consider private, state, local school system, and classroom based assessments, as applicable.)

Summary of Assessment Findings (including dates of administration): ____________________

Does this area impact the student's academic achievement and/or functional performance? ○ YES ○ NO

HEALTH ____________________

Source(s): ____________________

Level of Performance: ____________________

(Consider private, state, local school system, and classroom based assessments, as applicable.)

Summary of Assessment Findings (including dates of administration): ____________________

Does this area impact the student's academic achievement and/or functional performance? ○ YES ○ NO

PHYSICAL ____________________

Source(s): ____________________

Level of Performance: ____________________

(Consider private, state, local school system, and classroom based assessments, as applicable.)

Summary of Assessment Findings (including dates of administration): ____________________

Does this area impact the student's academic achievement and/or functional performance? ○ YES ○ NO

BEHAVIORAL ____________________

Source(s): ____________________

Level of Performance: ____________________

(Consider private, state, local school system, and classroom based assessments, as applicable.)

Summary of Assessment Findings (including dates of administration): ____________________

Does this area impact the student's academic achievement and/or functional performance? ○ YES ○ NO

Name: Agency: IEP Team Meeting Date: / /

PRESENT LEVEL OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

What is the parental input regarding the student's educational program?

What are the student's strengths, interest areas, significant personal attributes, and personal accomplishments? (Include preferences and interests for post-school outcomes, if appropriate.)

How does the student's disability affect his/her involvement in the general education curriculum?

For preschool age children, how does the disability affect participation in appropriate activities?

III. SPECIAL CONSIDERATIONS AND ACCOMMODATIONS

Name: Agency: IEP Team Meeting Date: / /

COMMUNICATION (required)

Does the student have special communication needs? ◯ YES ◯ NO

(If yes, describe the specific needs.) ______________________________

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ASSISTIVE TECHNOLOGY (AT) (required)

Consider AT device(s) and service(s) that are needed to increase, maintain or improve functional capabilities of a student with a disability.

Was assistive technology considered? ◯ YES ◯ NO

Does the student need an AT device(s)? ◯ YES ◯ NO

If yes, list AT device(s): ______________________________

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Does the student need an AT service(s)? ◯ YES ◯ NO

Document basis for decision(s): ______________________________

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SERVICE FOR STUDENTS WHO ARE BLIND OR VISUALLY IMPAIRED

In the case of a student who is blind or visually impaired, provide for instruction in Braille and the use of Braille unless the IEP Team determines, after an evaluation of the student's reading and writing media that instruction in Braille is not appropriate for the student.

Instruction in Braille considered? ◯ YES ◯ NO

Evaluation date: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

Is instruction in Braille appropriate? ◯ YES ◯ NO

Were parents provided information regarding Maryland School for the Blind? ◯ YES ◯ NO

Document basis for decision(s): ______________________________

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SERVICE FOR STUDENTS WHO ARE DEAF OR HEARING IMPAIRED

In the case of a student who is deaf or hearing impaired, consider language and communication needs, opportunities for direct communications, academic level, and full range of needs, including direct instruction in the student's language and communication mode.

Were parents provided information regarding Maryland School for the Deaf? ◯ YES ◯ NO

Document basis for decision(s): ______________________________

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____

Name: Agency: IEP Team Meeting Date: / /

BEHAVIORAL INTERVENTION

In the case of a student whose behavior impedes the student's learning or that of others, consider the use of positive behavioral interventions and supports, and other strategies to address that behavior.

○ Functional Behavioral Assessment (FBA) Assessment date: ☐☐•☐☐•☐☐☐☐

Does the student require a Behavioral Intervention Plan (BIP)? ○ YES ○ NO

○ Behavioral Intervention Plan Implementation date: ☐☐•☐☐•☐☐☐☐

Document basis for decision(s): ______________________________

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SERVICE FOR STUDENTS WITH LIMITED ENGLISH PROFICIENCY

In the case of a student with limited English proficiency, consider the language needs of the student as such needs relate to the student's IEP.

Document basis for decision(s): ______________________________

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____

Name: Agency: IEP Team Meeting Date: / /

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

PRESENTATION ACCOMMODATIONS:

	Visual Presentation Accommodations	Code	(1) Assessment: Standard Administration	(2) Assessment: Non-Standard Administration	(3) Use in Instruction
☐	Large Print	1-A	✔	N/A	✔
☐	Magnification Devices	1-B	✔	N/A	✔
☐	Sign Language	1-C	✔	N/A	✔
	Tactile Presentation Accommodations				
☐	Braille	1-D	✔	N/A	✔
☐	Tactile Graphics	1-E	*N/A	*N/A	✔
	Auditory Presentation Accommodations				
☐	Human Reader, Audio Tape, or Compact Disk Recording for Verbatim Reading of Entire Test	1-F	✔***	***	✔
☐	Human Reader, Audio Tape, or Compact Disk Recording for Verbatim Reading of Selected Sections of Test	1-G	✔***	***	✔
☐	Audio Amplification Devices	1-H	✔	N/A	✔
☐	Books on Tape	1-J	N/A	N/A	✔
☐	Recorded Books	1-K	N/A	N/A	✔
	Multi-Sensory Presentation Accommodations				
☐	Video Tape and Descriptive Video	1-L	**	N/A	✔
☐	Screen Reader for Verbatim Reading of Entire Test	1-M	✔***	***	✔
☐	Screen Reader for Verbatim Reading of Selected Sections of Test	1-N	✔***	***	✔
☐	Visual Cues	1-O	✔	N/A	✔
☐	Notes, Outlines, and Instructions	1-P	N/A	N/A	✔
☐	Talking Materials	1-Q	✔	N/A	✔
	Other Presentation Accommodations				
☐	Other	1-R	Determined on a case-by-case basis in consultation with MSDE		

*For purpose of State assessments, any tactile graphics needed are included with the Braille version of the test.

**No Maryland assessments currently incorporate video-taped stimulus materials. However, if video taped is used, students must have access to closed captioning or video materials, as appropriate.

*** (1) Use of the verbatim reading accommodation is permitted on all assessments as a standard accommodation, with the exception of the Maryland School Assessment (MSA) in reading, grades 3 and 4, which assess students' ability to decode printed language. Students in those grades receiving this accommodation on the assessment will receive a score based on standards 2 and 3 (comprehension of informational and literary reading material) but will not receive a score for standard 1, general reading processes.

*** (2) The Maryland Functional Reading Test.

Any screen reader may be used for instruction, but the only screen reader currently supported by the State for assessment is the Kurzweil™ 3000. In order for students to use the Kurzweil™ 3000 screen reader for testing, students must have used a screen reader in instruction and have had an opportunity to become familiar with the operation of the Kurzweil™ 3000 interface. Although a Human reader is always permissible to deliver a verbatim reading accommodation, the State encourages the use of screen readers on State testing, to promote standardization of the verbatim reading accommodation.

✔ Check indicates applicable accommodation(s).

Discussion to support decision: ______________________________

Name: Agency: IEP Team Meeting Date: / /

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

RESPONSE ACCOMMODATIONS:

	Response Accommodations	Code	(1) Assessment: Standard Administration	(2) Assessment: Non-Standard Administration	(3) Use in Instruction
	Scribe	2-A	✔	N/A	✔
	Speech-to-Text	2-B	✔	N/A	✔
	Large Print Response Booklet	2-C	✔	N/A	✔
	Brailler	2-D	✔	N/A	✔
	Electronic Note-Takers and Word Processors	2-E	✔	N/A	✔
	Tape Recorder	2-F	✔	N/A	✔
	Respond on Test Booklet	2-G	✔	N/A	✔
	Monitor Test Response	2-H	✔	N/A	✔
	Materials or Devices Used to Solve or Organize Responses				
	Calculation Devices	2-J	✔	N/A	✔
	Spelling and Grammar Devices	2-K	✔*	*	✔
	Visual Organizers	1-L	✔**	**	✔
	Graphic Organizers	2-M	✔	N/A	✔
	Bilingual Dictionaries	2-N	✔	N/A	✔
	Other Response Accommodations				
	Other	2-O	Determined on a case-by-case basis in consultation with MSDE		

* Spelling and grammar devices are not permitted to be used on the English High School Assessment.

** Photocopying of secure test materials requires approval and must be done under the supervision of the Local Accountability Coordinator (LAC). Photocopied materials must be securely destroyed under the supervision of the LAC. Use of highlighters may be limited on certain machine-scored test forms, as highlighting may obscure test responses. Check with the LAC before allowing the use of highlighters on any State assessment.

✔ Check indicates applicable accommodation(s).

Discussion to support decision: ______________________________

____

Name: Agency: IEP Team Meeting Date: / /

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

TIMING AND SCHEDULING ACCOMMODATIONS:

	Timing and Scheduling Accommodations	Code	(1) Assessment: Standard Administration	(2) Assessment: Non-Standard Administration	(3) Use in Instruction
	Extended Time	3-A	✔	N/A	✔
	Multiple or Frequent Breaks	3-B	✔	N/A	✔
	Change Schedule or Order of Activities — Extend over multiple days	3-C	✔	N/A	✔
	Change Schedule or Order of Activities — Within one day	3-D	✔	N/A	✔
	Other Timing and Scheduling Accommodations				
	Other	3-E	Determined on a case-by-case basis in consultation with MSDE		

✔ Check indicates applicable accommodation(s).

Discussion to support decision: ______________________________

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SETTING ACCOMMODATIONS:

	Setting Accommodations	Code	(1) Assessment: Standard Administration	(2) Assessment: Non-Standard Administration	(3) Use in Instruction
	Reduce Distractions to the Student	4-A	✔	N/A	✔
	Reduce Distractions to Other Students	4-B	✔	N/A	✔
	Change Location to Increase Physical Access or to Use Special Equipment — Within School Building	4-C	✔	N/A	✔
	Change Location to Increase Physical Access or to Use Special Equipment — Outside School Building	4-D	✔	N/A	✔
	Other Setting Accommodations				
	Other	4-E	Determined on a case-by-case basis in consultation with MSDE		

✔ Check indicates applicable accommodation(s).

Discussion to support decision: ______________________________

____

○ Instructional and testing accommodations were considered and no instructional and testing accommodations are required at this time.

Discussion to support decision: ______________________________

Name: Agency: IEP Team Meeting Date: / /

SUPPLEMENTARY AIDS, SERVICES, PROGRAM MODIFICATIONS AND SUPPORTS

Service Nature	Service Description	Begin Date	End Date	Provider(s) ◯ = Primary, ◯ = Other
◯ ___________________	Anticipated Frequency ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Periodically ◯ Other __________	MM•DD•YYYY	MM•DD•YYYY	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency_________________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider__________________ Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist

Clarify the location and manner in which Supplementary Aids, Services, Program Modifications and Supports to or, on behalf of, the student will be provided: ____________________

____

Discussion to support decisions: ____

____

____

◯ Supplementary Aids, Services, Program Modifications and Supports were considered and none are required at this time.

Discussion to support decision(s): ____

Name: Agency: IEP Team Meeting Date: / /

EXTENDED SCHOOL YEAR (ESY)

The IEP Team should determine if any of the factors below will significantly jeopardize the student's ability to receive some benefit from the student's educational program during the regular school year, if the student does not receive ESY services. ESY services are the individualized extension of specific special education and related services that are provided beyond the normal school year of the public agency, in accordance with the IEP, at no cost to the parents.

○ ESY Decision Deferred

When considering ESY, answer YES or NO and document the decision:

1. Does the student's IEP include annual goals related to critical life skills? ○ YES ○ NO

   Discussion to support decision: ______________________________

   ____

   1a. Is there a likely chance of substantial regression of critical life skills caused by the normal school break and a failure to recover those lost skills in a reasonable time? ○ YES ○ NO

   Discussion to support decision: ______________________________

   ____

   1b. Is the student demonstrating a degree of progress toward mastery of IEP goals related to critical life skills? ○ YES ○ NO

   Discussion to support decision: ______________________________

   ____

2. Is there a presence of emerging skills or breakthrough opportunities? ○ YES ○ NO

   Discussion to support decision: ______________________________

   ____

3. Are there significant interfering behaviors? ○ YES ○ NO

   Discussion to support decision: ______________________________

   ____

4. Does the nature and severity of the disability warrant ESY? ○ YES ○ NO

   Discussion to support decision: ______________________________

   ____

5. Are there other special circumstances that require ESY? ○ YES ○ NO

   Discussion to support decision: ______________________________

   ____

After considering all of the above questions, will the benefits that the student receives from his/her educational program during the regular school year be significantly jeopardized if the student is not provided ESY? ○ YES, student will receive ESY service.
○ NO, student will not receive ESY service.

Document basis for decision(s): ______________________________

____

Name: Agency: IEP Team Meeting Date: / /

TRANSITION (To be completed annually, beginning at age 14 or younger, if determined appropriate.)

STUDENT PREFERENCES AND INTERESTS:
The postsecondary goal(s) are to be based on the student's interests, preferences and age appropriate transition assessments.

Date of Student Interview: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

Discussion of student's interests, preferences and age appropriate transition assessments: ______________________________

____

POSTSECONDARY GOALS:
Postsecondary goal(s) are to be recorded here. At least one goal must be indicated for training and/or education.

Training: ______________________________

Education: ______________________________

Employment (required): ______________________________

Independent Living (if appropriate): ______________________________

COURSE OF STUDY:

The course of study is to support the stated postsecondary goal(s)

- ◯ Arts, Media & Communication
- ◯ Education, Training & Child Services
- ◯ Engineering, Scientific Research & Manufacturing Technology
- ◯ Law, Government, Public Safety & Administration
- ◯ Business Management & Finance
- ◯ Health, Bioscience, & Medicine
- ◯ Environmental, Agricultural & Natural Resource Systems
- ◯ Human, Consumer Services, Hospitality & Tourism
- ◯ Construction & Development
- ◯ Information Technology
- ◯ Transportation, Distribution & Logistics

Student is enrolled in the following Functional and Skill Development Activities:

◯ Job Sampling & Employment training ◯ Supported Employment ◯ Activities of Daily Living

PROJECTED DATE OF EXIT:
The student is projected to exit/graduate school ______________________________ (month, day, year)

Have the student and parents been informed that rights under IDEA do not transfer to students with disabilities on reaching age of majority, except under limited circumstances, as described in Education Article §8-412.1, Annotated Code of Maryland? ◯ Yes ◯ N/A

PROJECTED CATEGORY OF EXIT:
The student will exit with: ◯ Maryland High School Diploma
- ☐ with 2 credits of Foreign Language
- ☐ with 2 credits of Advanced Technology
- ☐ with 4 credits of Career and Technology Program

◯ Certificate of Program Completion at age 21
◯ Certificate of Program Completion prior to age 21

AGENCY LINKAGE:
The student has been referred to the appropriate agency for transition and/or postsecondary services:
◯ DORS (Department of Rehabilitative Services)
◯ DDA (Developmental Disabilities Agency)
◯ MHA (Mental Hygiene Administration)

Document basis for decision(s): ______________________________

____

Name: Agency: IEP Team Meeting Date: / /

TRANSITION ACTIVITIES

TRANSITION SERVICES/ACTIVITIES:
Transition services are a coordinated set of activities for a student with a disability that is designed within a results oriented process that will facilitate the student's movement from school to postsecondary activities.

Academic: ______________________________

____

Responsible Party: ______________________________

Employment Training: ______________________________

____

Responsible Party: ______________________________

Activities of Daily Living: ______________________________

____

Responsible Party: ______________________________

Independent Living: ______________________________

____

Responsible Party: ______________________________

Transportation: ______________________________

____

Responsible Party: ______________________________

Name: Agency: IEP Team Meeting Date: / /

ANTICIPATED SERVICES FOR TRANSITION

Services you anticipate a student 14 years and older will need within one year of exiting the agency. The adult services recommended on this page are those anticipated and not entitlement services.

General Services

- ◯ No Services Needed: upon exiting from the educational system.
- ◯ Public income maintenance: Social Security Income (SSI), Social Security Disability Income (SSDI), welfare, Medicaid, public health insurance, etc.
- ◯ Transportation: specialized transportation including paratransit.

Further Education/Training

- ◯ Continuing and Adult Education: including Adult Basic Ed (ABE), General Education Development (GED), adult high school diploma, and adult compensatory or special education.
- ◯ Higher Education Support Services: note takers, educational technology, modified testing time, mentoring and guidance, study skills, and self advocacy training.
- ◯ Career School Support Services: support services in programs such as career schools, Job Training Partnership Act programs (JTPA), and Job Corps.

Division of Rehabilitation Services (DORS)

- ◯ Assessment and Evaluation
- ◯ Vocational Rehabilitation Counseling and Guidance
- ◯ Job Search, Placement Assistance, and Follow Up Services
- ◯ Medical Rehabilitation
- ◯ Vocational and Other Training Services
- ◯ Rehabilitation Technology Services
- ◯ Support Services

Developmental Disabilities Administration (DDA)

- ◯ Day Habilitation
- ◯ Community Residential Services
- ◯ Supported Employment
- ◯ Family and Individual Support Services
- ◯ Behavior/Support Services
- ◯ Community Supported Living Arrangements (CSLA)

Mental Hygiene Administration (MHA)

- ◯ Mental Health Evaluation and Treatment
- ◯ Psychiatric Rehabilitation Programs
- ◯ Residential Rehabilitation Programs
- ◯ Supported Employment
- ◯ Respite Care

Name: Agency: IEP Team Meeting Date: / /

GOAL ______________________

Goal: ____

____

____

____

By: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

Evaluation Method: ☐ INFORMAL PROCEDURES ☐ CLASSROOM-BASED ASSESSMENT ☐ OBSERVATION RECORD ☐ STANDARDIZED ASSESSMENT ☐ PORTFOLIO ASSESSMENT ☐ OTHER ___________

With ___________ ☐ % Accuracy ☐ % decrease ☐ ____ out of ____ trials ☐ % increase ☐ other________

ESY goal? ◯ YES ◯ NO

Objective 1: ____

Objective 2: ____

Objective 3: ____

Objective 4: ____

Progress Toward Goal	
Progress Report 1 Date_______	Progress Code: ◯ Achieved ◯ Making sufficient progress to meet goal ◯ Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) ◯ Not yet introduced Description: ______________________
Progress Report 2 Date_______	Progress Code: ◯ Achieved ◯ Making sufficient progress to meet goal ◯ Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) ◯ Not yet introduced Description: ______________________
Progress Report 3 Date_______	Progress Code: ◯ Achieved ◯ Making sufficient progress to meet goal ◯ Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) ◯ Not yet introduced Description: ______________________
Progress Report 4 Date_______	Progress Code: ◯ Achieved ◯ Making sufficient progress to meet goal ◯ Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) ◯ Not yet introduced Description: ______________________
Progress Report 5 Date_______	Progress Code: ◯ Achieved ◯ Making sufficient progress to meet goal ◯ Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) ◯ Not yet introduced Description: ______________________

How will the parent be notified of the student's progress toward the IEP goals? ______________________

How often? ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY ☐ INTERIM ☐ QUARTERLY ☐ OTHER _______________

Name: Agency: IEP Team Meeting Date: / /

SERVICES

◯ SPECIAL EDUCATION SERVICES

Service Nature	Location	Service Description			Begin Date	End Date	Provider(s) Ⓟ = Primary, ◯ = Other	Summary of Service
◯ Classroom Instruction (Identifying the number of sessions for Classroom Instruction is optional) ◯ Physical Education ◯ Speech/Language Therapy ◯ Travel Training	◯ In General Education ◯ Outside General Education	Number of Sessions ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Other ____	Length of Time (Select the length of time, in 15 minute increments, that the service is provided during each session) ◯ 15 Min. ◯ 30 Min. ◯ 45 Min. ◯ 1 Hr. ◯ 1 Hr. 15 Min. ◯ 1 Hr. 30 Min. ◯ 2 Hrs. ◯ 3 Hrs. ◯ Other ______	Frequency ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Recheck Periodically	MM•DD YYYY	MM•DD YYYY	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency____________________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider____________________ Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist	Total service time: ◯ weekly ◯ monthly ◯ yearly ____Hrs. ____Min.
ESY Service Nature	**ESY Location**	**ESY Service Description**			**ESY Begin Date**	**ESY End Date**	**ESY Provider(s) Ⓟ = Primary, ◯ = Other**	**Summary of Service**
◯ Classroom Instruction (Identifying the number of sessions for Classroom Instruction is optional) ◯ Physical Education ◯ Speech/Language Therapy ◯ Travel Training	◯ In General Education ◯ Outside General Education	Number of Sessions ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Other ____	Length of Time (Select the length of time, in 15 minute increments, that the service is provided during each session) ◯ 15 Min. ◯ 30 Min. ◯ 45 Min. ◯ 1 Hr. ◯ 1 Hr. 15 Min. ◯ 1 Hr. 30 Min. ◯ 2 Hrs. ◯ 3 Hrs. ◯ Other ______	Frequency ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Recheck Periodically	MM•DD YYYY	MM•DD YYYY	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency____________________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider____________________ Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist	Total service time: ◯ weekly ◯ monthly ◯ yearly ____Hrs. ____Min.

Discussion of service(s) delivery:____

Name: Agency: IEP Team Meeting Date: / /

SERVICES

○ RELATED SERVICES

Service Nature	Location	Service Description			Begin Date	End Date	Provider(s) Ⓟ = Primary, ○ = Other	Summary of Service
○ Audiological Services ○ Psychological Services ○ Occupational Therapy ○ Physical Therapy ○ Recreation ○ Early Identification &Assessment ○ Counseling Services ○ School Health Services ○ Social Work Services ○ Parent Counseling & Training ○ Rehabilitative Counseling ○ Orientation & Mobility Training Services ○ Assistive Technology Services ○ Medical Services (Diagnostic & Evaluation) ○ Other Therapies ____________ ○ Interpreting Services ○ Speech/Language Therapy	○ In General Education ○ Outside General Education	Number of Sessions ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ Other _____	Length of Time (Select the length of time, in 15 minute increments, that the service is provided during each session) ○ 15 Min. ○ 30 Min. ○ 45 Min. ○ 1 Hr. ○ 1 Hr. 15 Min. ○ 1 Hr. 30 Min. ○ 2 Hrs. ○ 3 Hrs. ○ Other ______	Frequency ○ Weekly ○ Monthly ○ Yearly ○ Only once ○ Recheck Periodically	MM•DD YYYY	MM•DD YYYY	Ⓟ ○ Orientation & Mobility Specialist Ⓟ ○ Speech/Language Pathologist Ⓟ ○ Teacher of the Hearing Impaired Ⓟ ○ Teacher of the Visually Impaired Ⓟ ○ Occupational Therapist Ⓟ ○ Pupil Personnel Worker Ⓟ ○ Physical Education Tchr Ⓟ ○ Rehabilitation Services Staff Ⓟ ○ General Education Tchr Ⓟ ○ Career & Technology Tchr Ⓟ ○ Department of Social Services (DSS) Ⓟ ○ Mental Hygiene Administration (MHA) Ⓟ ○ Developmental Disabilities Administration (DDA) Ⓟ ○ Division of Rehabilitation Services (DORS) Ⓟ ○ Other Agency________________________ Ⓟ ○ Special Education Classroom Teacher Ⓟ ○ Other Service Provider________________ Ⓟ ○ Audiologist Ⓟ ○ Psychologist Ⓟ ○ IEP Team Ⓟ ○ Interpreter Ⓟ ○ Instructional Assistant Ⓟ ○ Physical Therapist Ⓟ ○ Home-Based Teacher Ⓟ ○ Guidance Counselor Ⓟ ○ School Social Worker Ⓟ ○ Recreational Therapist	Total service time: ○ weekly ○ monthly ○ yearly ____Hrs. ____Min.

ESY Service Nature	ESY Location	ESY Service Description			ESY Begin Date	ESY End Date	ESY Provider(s) Ⓟ = Primary, ○ = Other	Summary of Service
○ Audiological Services ○ Psychological Services ○ Occupational Therapy ○ Physical Therapy ○ Recreation ○ Early Identification &Assessment ○ Counseling Services ○ School Health Services ○ Social Work Services ○ Parent Counseling & Training ○ Rehabilitative Counseling ○ Orientation & Mobility Training Services ○ Assistive Technology Services ○ Medical Services (Diagnostic & Evaluation) ○ Other Therapies ____________ ○ Interpreting Services ○ Speech/Language Therapy	○ In General Education ○ Outside General Education	Number of Sessions ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ Other _____	Length of Time (Select the length of time, in 15 minute increments, that the service is provided during each session) ○ 15 Min. ○ 30 Min. ○ 45 Min. ○ 1 Hr. ○ 1 Hr. 15 Min. ○ 1 Hr. 30 Min. ○ 2 Hrs. ○ 3 Hrs. ○ Other ______	Frequency ○ Weekly ○ Monthly ○ Yearly ○ Only once ○ Recheck Periodically	MM•DD YYYY	MM•DD YYYY	Ⓟ ○ Orientation & Mobility Specialist Ⓟ ○ Speech/Language Pathologist Ⓟ ○ Teacher of the Hearing Impaired Ⓟ ○ Teacher of the Visually Impaired Ⓟ ○ Occupational Therapist Ⓟ ○ Pupil Personnel Worker Ⓟ ○ Physical Education Tchr Ⓟ ○ Rehabilitation Services Staff Ⓟ ○ General Education Tchr Ⓟ ○ Career & Technology Tchr Ⓟ ○ Department of Social Services (DSS) Ⓟ ○ Mental Hygiene Administration (MHA) Ⓟ ○ Developmental Disabilities Administration (DDA) Ⓟ ○ Division of Rehabilitation Services (DORS) Ⓟ ○ Other Agency________________________ Ⓟ ○ Special Education Classroom Teacher Ⓟ ○ Other Service Provider________________ Ⓟ ○ Audiologist Ⓟ ○ Psychologist Ⓟ ○ IEP Team Ⓟ ○ Interpreter Ⓟ ○ Instructional Assistant Ⓟ ○ Physical Therapist Ⓟ ○ Home-Based Teacher Ⓟ ○ Guidance Counselor Ⓟ ○ School Social Worker Ⓟ ○ Recreational Therapist	Total service time: ○ weekly ○ monthly ○ yearly ____Hrs. ____Min.

Discussion of service(s) delivery:____

____

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Effective July 1, 2007)

Name: Agency: IEP Team Meeting Date: / /

SERVICES

◯ CAREER AND TECHNOLOGY EDUCATION SERVICES

Service Nature	Location	Service Description			Begin Date	End Date	Provider(s) ◯ = Primary, ◯ = Other		Summary of Service
◯ Career and Technology Education Program w/Support Services ◯ Special Career and Technology Education Program for Disabled ◯ Vocational Evaluation ◯ Special Education Program with Pre-Vocation Objectives	◯ In General Education ◯ Outside General Education	Number of Sessions ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Other ____	Length of Time (Select the length of time, in 15 minute increments, that the service is provided during each session) ◯ 15 Min. ◯ 30 Min. ◯ 45 Min. ◯ 1 Hr. ◯ 1 Hr. 15 Min. ◯ 1 Hr. 30 Min. ◯ 2 Hrs. ◯ 3 Hrs. ◯ Other ______	Frequency ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Recheck Periodically	MM•DD YYYY	MM•DD YYYY	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency____________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider______________	Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist	Total service time: ◯ weekly ◯ monthly ◯ yearly ____Hrs. ____Min.

ESY Service Nature	ESY Location	ESY Service Description			ESY Begin Date	ESY End Date	ESY Provider(s) ◯ = Primary, ◯ = Other		Summary of Service
◯ Career and Technology Education Program w/Support Services ◯ Special Career and Technology Education Program for Disabled ◯ Vocational Evaluation ◯ Special Education Program with Pre-Vocation Objectives	◯ In General Education ◯ Outside General Education	Number of Sessions ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Other ____	Length of Time (Select the length of time, in 15 minute increments, that the service is provided during each session) ◯ 15 Min. ◯ 30 Min. ◯ 45 Min. ◯ 1 Hr. ◯ 1 Hr. 15 Min. ◯ 1 Hr. 30 Min. ◯ 2 Hrs. ◯ 3 Hrs. ◯ Other ______	Frequency ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Recheck Periodically	MM•DD YYYY	MM•DD YYYY	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency____________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider______________	Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist	Total service time: ◯ weekly ◯ monthly ◯ yearly ____Hrs. ____Min.

Discussion of service(s) delivery:____

____

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Effective July 1, 2007)

VI. PLACEMENT DATA

Name: Agency: IEP Team Meeting Date: / /

LEAST RESTRICTIVE ENVIRONMENT (LRE) DECISION MAKING & PLACEMENT SUMMARY

A student with a disability is not removed from general education in an age-appropriate instructional setting solely because of needed modifications to the general curriculum.

What placement option(s) did the IEP team consider? ______

If removed from the general education environment, explain reasons why services cannot be provided in the general education environment with the use of supplementary aids and services: ______

Document basis for decision(s): ______

{Total time in school week: ______hrs.______minutes/week} − {Total time outside of General Education:______hrs.______minutes/week} = {Total time in General Education:______hrs.______minutes/week}

◯ Special education placement (ages 3-5): Average ______ %/day

- ☐ IN REGULAR EARLY CHILDHOOD SETTING (at least 80%)
- ☐ IN REGULAR EARLY CHILDHOOD SETTING (40% - 79%)
- ☐ IN REGULAR EARLY CHILDHOOD SETTING (less than 40%)
- ☐ SEPARATE CLASS
- ☐ PUBLIC SEPARATE DAY SCHOOL
- ☐ PRIVATE SEPARATE DAY SCHOOL
- ☐ PUBLIC RESIDENTIAL FACILITY
- ☐ PRIVATE RESIDENTIAL FACILITY
- ☐ HOME
- ☐ SERVICE PROVIDER LOCATION

◯ Special education placement (ages 6-21): Average ______ %/day

- ☐ INSIDE GENERAL EDUCATION (80% or more)
- ☐ INSIDE GENERAL EDUCATION (40% - 79%)
- ☐ INSIDE GENERAL EDUCATION (less than 40%)
- ☐ PUBLIC SEPARATE DAY SCHOOL
- ☐ PRIVATE SEPARATE DAY SCHOOL
- ☐ PUBLIC RESIDENTIAL FACILITY
- ☐ PRIVATE RESIDENTIAL FACILITY
- ☐ HOMEBOUND/HOSPITAL
- ☐ CORRECTIONAL FACILITIES
- ☐ PARENTALLY PLACED IN PRIVATE SCHOOL

In selecting the LRE, are there any potential harmful effects on the student or quality of services he or she needs? ◯ YES ◯ NO

If yes, document basis for decision(s): ______

Are the services ***in*** the student's home school (the school the student would attend if not disabled)? ◯ YES ◯ NO If no, document basis for decision(s): ______

If no, is placement as ***close as possible to*** the student's home? ◯ YES ◯ NO If no, document basis for decision(s): ______

Is special transportation needed? ◯ YES ◯ NO If Yes, list all specialized equipment, if needed: ______

Are personnel needed to assist the student during transportation? ◯ YES ◯ NO If yes, explain: ______

Document basis for decision(s) (including consideration of the amount of time and distance involved in travel): ______

Provide an explanation to the extent, if any, the student will not participate with non-disabled peers in academic, non-academic, and extracurricular activities?

______

SSIS Residence County______ SSIS Residence School ______

SSIS Service County ______ SSIS Service School______

CHILD COUNT ELIGIBILITY CODES

- ☐ (1) Eligible student with a disability served in a public school or placed in a nonpublic school by the public agency to receive FAPE.
- ☐ (2) Eligible parentally placed private school student with a disability receiving special education and/or related service through a service plan from the public agency.
- ☐ (3) Eligible parentally placed private school student with a disability NOT receiving service from the public agency.

Name: Agency: IEP Team Meeting Date: / /

AUTHORIZATION(S)

CONSENT FOR INITIATION OF SERVICES (initial IEP only)

I have received a copy of the Evaluation Report informing me in writing of the reasons for this action.

The special education and related services will be provided as described in the IEP. I understand that the IEP will be reviewed periodically but not less than annually.

I understand that records will not be released without my signed and written consent except under the provisions of the Family Education Rights and Privacy Act (FERPA). This law allows the release of educational records to a public school or educational agency.

I understand that my consent is voluntary and that I may revoke consent at any time. Should I revoke consent it is not retroactive.

I understand that the public agency will submit information that will be used for the special services information system. This system will be used by the MSDE and other State Agencies, as appropriate, to enable funding of programs and to assure my child's rights to any needed assessment.

I have been informed of the determination(s) of the IEP team in my native language or other mode of communication.

I have been informed of my rights, as explained in the *Procedural Safeguards - Parental Rights* document, I have received.

I consent to the initiation of special education and related services for my child, as specified in my child's IEP.

Parent Signature: ______________________________ **Date:** ______________

MEDICAL ASSISTANCE (MA)

Is the student eligible for MA? ◯ Yes ◯ No **MA Number** ____________________

I agree to Service Coordination for Children with Disabilities and that the Service Coordinator(s) identified on this IEP may be appointed as MA Service Coordinator(s). (COMAR 10.09.52)

I understand that I am free to choose an MA Service Coordinator for my child. At this time, I accept the following Service Coordinator(s).

MA Service Coordinator Name: ____________________________

MA Service Coordinator Name: ____________________________

I understand that if I wish to change the MA Service Coordinator in the future, I can call the school to make a change.

I understand that the purpose of this service is to assist in gaining access to needed medical, social, educational, and other services.

I give permission to the local school system to recover costs from Medicaid for service coordination, as well as health-related services, related to the implementation of my child's IEP goals.

I understand that if I refuse to allow the public agency access to MA funds, it does not relieve the public agency of its responsibility to ensure that all required services are provided to my child at no cost to parent.

I understand that this service does not restrict or otherwise affect my child's eligibility for other Medical Assistance benefits. I also understand that my child may not receive a similar type of case management service under Medical Assistance if he/she qualifies for more than one type.

I understand that the public agency will submit information that will be used for the special services information system. This system will be used by the MSDE and other State Agencies, as appropriate, to enable funding of programs and to assure my child's rights to any needed assessment.

Parent Signature: ______________________________ **Date:** ______________