

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2015)

Student Information

Draft _____
 Approved _____
 Amended _____

Name: _____

Agency: _____

IEP Team Meeting Date: / /

STUDENT AND SCHOOL INFORMATION

First Name: _____ Middle Name: _____ 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 CODES

Ethnicity: Hispanic or Latino Yes No

American Indian or Alaskan Native Native Hawaiian or other Pacific Islander

Asian

Black or African American

White

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.

The parents were provided a verbal and written explanation of the parents' rights and responsibilities in the IEP team process.

Parents were provided verbal and written information about access to rehabilitative services, including a copy of the Maryland Insurance Administration's Parents' Guide to Habilitative Services.

Projected Annual Review Date: _____

Most Recent Evaluation Date: _____

Projected Evaluation Date: _____

Primary Disability: _____

Areas affected by Disability: _____

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 J - Parent revokes consent for services

IEP TEAM PARTICIPANTS

IEP Case Manager: _____

Principal/Designee: _____

School Psychologist: _____

Agency Representative: _____

IEP Chair: _____

General Educator: _____

Social Worker: _____

Others in attendance: _____

Parent/Guardian: _____

Special Educator: _____

Speech/Language Pathologist: _____

Others in attendance: _____

Parent/Guardian: _____

Guidance Counselor: _____

Student: _____

Others in attendance: _____

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I. MEETING AND IDENTIFYING INFORMATION

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 must otherwise meet the eligibility criteria as a student with an identified disability.)

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

Initial Eligibility (Prior to Age 3)

Child is eligible for preschool special education and related services through an IEP. Yes No

Indicate primary disability

- AUTISM
- DEVELOPMENTAL DELAY
- INTELLECTUAL DISABILITY
- SPECIFIC LEARNING DISABILITY
- VISUAL IMPAIRMENT
- DEAF
- EMOTIONAL DISABILITY
- ORTHOPEDIC IMPAIRMENT
- SPEECH OR LANGUAGE IMPAIRMENT
- MULTIPLE DISABILITIES
- DEAF - BLINDNESS
- HEARING IMPAIRMENT
- OTHER HEALTH IMPAIRMENT
- TRAUMATIC BRAIN INJURY
- Cognitive (specify) _____
- Sensory (specify) _____
- Physical (specify) _____

Document basis for decision(s): _____

Date of parent consent for initial evaluation

 (MM•DD•YYYY)

Date of initial evaluation:

 (MM•DD•YYYY)

Reason(s) for delay of initial evaluation:

Eligibility not determined due to withdrawal of consent, moved from district, child unavailable as a result of chronic condition or illness.

Initial evaluation

If evaluation for child was delayed, indicate reason(s) for delay:

- Parent repeatedly failed or refused to make the child available
- Parent refusal to provide consent caused delay in evaluation or initial services
- Parent requested delay - Parent and IEP team extend the timeframe by mutual written agreement
- School/facility closure
- Inclement weather
- Other

- Staffing issues
- Paperwork error
- Inconclusive testing results
- Other, please specify: _____

Date of Parent Consent-Continue Early Intervention Services through an IFSP at age 3.

 (MM•DD•YYYY)

Date of initial IEP development:

 (MM•DD•YYYY)

Date of parent consent for initiation of services:

 (MM•DD•YYYY)

Date initial IEP is in effect:

 (MM•DD•YYYY)

Is this student transitioning from Infants and Toddlers (Part C) to Preschool (Part B) and receiving services through an IEP? YES NO

Reason(s) for delay of IEP in effect by age 3

Eligibility not determined due to withdrawal of consent, moved from district, child unavailable as a result of chronic condition or illness.

Initial IEP in effect by age 3

If IEP not in effect by age 3, indicate reason(s) for delay:

- Parent repeatedly failed or refused to make the child available
- Parent refusal to provide consent caused delay in evaluation or initial services
- Parent requested delay - Parent and IEP team extend the timeframe by mutual written agreement
- School/facility closure
- Inclement weather
- Other

- Staffing issues
- Paperwork error
- Inconclusive testing results
- Other, please specify: _____

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.

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Name: _____ Agency: _____ IEP Team Meeting Date: / /

Initial Eligibility (Student Ages 3-21)

Child is eligible as a student with a disability for special education and related services. Yes No

Indicate primary disability

- | | | | | |
|--|--|---|---|---|
| <input type="radio"/> AUTISM | <input type="radio"/> DEVELOPMENTAL DELAY | <input type="radio"/> INTELLECTUAL DISABILITY | <input type="radio"/> SPECIFIC LEARNING DISABILITY | <input type="radio"/> VISUAL IMPAIRMENT |
| <input type="radio"/> DEAF | <input type="radio"/> EMOTIONAL DISABILITY | <input type="radio"/> ORTHOPEDIC IMPAIRMENT | <input type="radio"/> SPEECH OR LANGUAGE IMPAIRMENT | <input type="radio"/> MULTIPLE DISABILITIES |
| <input type="radio"/> DEAF - BLINDNESS | <input type="radio"/> HEARING IMPAIRMENT | <input type="radio"/> OTHER HEALTH IMPAIRMENT | <input type="radio"/> TRAUMATIC BRAIN INJURY | <input type="radio"/> Cognitive (specify) _____ |
| | | | | <input type="radio"/> Sensory (specify) _____ |
| | | | | <input type="radio"/> Physical (specify) _____ |

Document basis for decision(s): _____

Date of parent consent for initial evaluation • • (MM•DD•YYYY)
Date of initial evaluation: • • (MM•DD•YYYY)

Reason(s) for delay of initial evaluation

- Eligibility not determined due to withdrawal, i.e., transfer, dropout, parent withdrew consent.
- Initial evaluation
- If evaluation was delayed, indicate reason(s) for delay:
- | | |
|--|---|
| <input type="radio"/> Parent repeatedly failed or refused to make the child available | <input type="radio"/> Parent requested delay - Parent and IEP team extend the timeframe by mutual written agreement |
| <input type="radio"/> Student is enrolled after 60-day timeframe began and prior to determination by LSS. Receiving LSS made sufficient progress to complete the evaluation and parent and LSS agreed to a specific time to complete the evaluation (All conditions must be met) | <input type="radio"/> School/facility closure |
| | <input type="radio"/> Inclement weather |
| | <input type="radio"/> Other |
| | <input type="radio"/> Paperwork error |
| | <input type="radio"/> Child not available (not parent failure)/child refusal |
| | <input type="radio"/> Inconclusive testing results |
| | <input type="radio"/> Staffing issues |
| | <input type="radio"/> Other, please specify _____ |

Date of Parent Consent-Continue Early Intervention Services through an IFSP at age 3: • • (MM•DD•YYYY)

Date local school system was notified of parent decision to request services through an IEP: • • (MM•DD•YYYY)
Date extended IFSP services ended: • • (MM•DD•YYYY)
Date of initial IEP development: • • (MM•DD•YYYY)
Date of parent consent for initiation of services: • • (MM•DD•YYYY)
Date initial IEP is in effect: • • (MM•DD•YYYY)

Is this student transitioning from Infants and Toddlers (Part C) to Preschool (Part B) and receiving services through an IEP? 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

- | | | | | |
|--|--|---|---|---|
| <input type="radio"/> AUTISM | <input type="radio"/> DEVELOPMENTAL DELAY | <input type="radio"/> INTELLECTUAL DISABILITY | <input type="radio"/> SPECIFIC LEARNING DISABILITY | <input type="radio"/> VISUAL IMPAIRMENT |
| <input type="radio"/> DEAF | <input type="radio"/> EMOTIONAL DISABILITY | <input type="radio"/> ORTHOPEDIC IMPAIRMENT | <input type="radio"/> SPEECH OR LANGUAGE IMPAIRMENT | <input type="radio"/> MULTIPLE DISABILITIES |
| <input type="radio"/> DEAF - BLINDNESS | <input type="radio"/> HEARING IMPAIRMENT | <input type="radio"/> OTHER HEALTH IMPAIRMENT | <input type="radio"/> TRAUMATIC BRAIN INJURY | <input type="radio"/> Cognitive (specify) _____ |
| | | | | <input type="radio"/> Sensory (specify) _____ |
| | | | | <input type="radio"/> Physical (specify) _____ |

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

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Name:

Agency:

IEP Team Meeting Date: / /

STUDENT PARTICIPATION ON DISTRICT/STATEWIDE ASSESSMENTS AND GRADUATION INFORMATION

PLAN FOR PARTICIPATION IN ASSESSMENTS TO BE ADMINISTERED DURING THE TERM OF THE CURRENT IEP*

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

Also record any additional local school system graduation requirements:

Graduation requirements explained to parents? YES NO

Will the student participate in an alternate assessment based on alternate academic achievement standards in assessed grade in

•reading •math •science? YES NO

Student is pursuing a:

Maryland High School Diploma Maryland High School Certificate of Program Completion

Will the student participate in the Maryland School Assessment aligned with grade level academic achievement standards in assessed grade? (Grades 5 and 8)

Science YES NO

Will the student participate in the Maryland High School Assessment in assessed course?

Algebra/Data Analysis YES NO Biology YES NO English YES NO Government YES NO

Will the student participate in the Maryland High School Assessment aligned with Modified Achievement Standards in assessed course?

(Only available to second time test takers and only available through August 2015)

Algebra/Data Analysis YES NO Biology YES NO English YES NO Government YES NO

Will the student participate in the PARCC Assessments for grades 3 through 8?

English Language Arts/Literacy YES NO Mathematics YES NO

Will the student participate in the PARCC Assessments for high school?

English Language Arts/literacy YES NO Algebra I YES NO Geometry YES NO Algebra II YES NO

Document basis for assessment decision(s): _____

*** A STUDENT MAY BE ASKED TO PARTICIPATE IN NATIONAL OR INTERNATIONAL ASSESSMENTS. ONLY ALLOWABLE ACCOMMODATIONS ON NATIONAL/INTERNATIONAL ASSESSMENTS ARE PERMITTED.**

Complete for high school seniors that may be eligible for an HSA waiver

IEP team has discussed the criteria of the waiver decision-making process for the student and supports an HSA waiver recommendation to the local superintendent.

YES (If yes, specify date recommended) _____ NO

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IEP Team Meeting Date: / /

PERFORMANCE SUMMARY

Is the student limited English proficient? YES NO

What was the student's performance on the Assessing Comprehension and Communication in English State-to-State for English Language Learners (ACCESS for ELLs)?

Assessment Date . . (MM•DD•YYYY) Overall Composite Proficiency Level _____

ENTERING EMERGING DEVELOPING EXPANDING BRIDGING REACHING

What was the student's performance on the Alternate Assessing Comprehension and Communication in English State-to-State for English Language Learners (Alternate ACCESS for ELLs)?

Assessment Date . . (MM•DD•YYYY) Overall Composite Proficiency Level _____

INITIATING EXPLORING ENGAGING ENTERING EMERGING

What was the student's performance on MSA as of . . ?

What was the student's performance, if applicable, on HSA as of . . ?

MSA Assessments	Most Current Proficiency Levels			Current Scale Score	Last Year's Scale Score
	<input type="radio"/> BASIC	<input type="radio"/> PROFICIENT	<input type="radio"/> ADVANCED		
Reading	<input type="radio"/> BASIC	<input type="radio"/> PROFICIENT	<input type="radio"/> ADVANCED		
Math	<input type="radio"/> BASIC	<input type="radio"/> PROFICIENT	<input type="radio"/> ADVANCED		
Science	<input type="radio"/> BASIC	<input type="radio"/> PROFICIENT	<input type="radio"/> ADVANCED		

HSA Assessments (Check Mod, if appropriate.)	Passing Score	Student's 1st Score	Student's 2nd Score	Student's Highest Score	Meets Standard	Bridge Plan Participant	Mod-HSA + Participant
Algebra/ Data Analysis <input type="checkbox"/> Mod	412				<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
Biology <input type="checkbox"/> Mod	400				<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
English <input type="checkbox"/> Mod	396				<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
Government <input type="checkbox"/> Mod	394				<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
Combined Score with Gov't	1602				<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
Combined Score w/out Gov't	1208				<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N

What was the student's performance, if applicable, on alternate assessments as of

. . ?

What was the student's performance on PARCC Assessments?

Alternate Assessments	% of Mastery Objectives	Most Current Proficiency Levels		
		<input type="radio"/> BASIC	<input type="radio"/> PROFICIENT	<input type="radio"/> ADVANCED
Reading		<input type="radio"/> BASIC	<input type="radio"/> PROFICIENT	<input type="radio"/> ADVANCED
Math		<input type="radio"/> BASIC	<input type="radio"/> PROFICIENT	<input type="radio"/> ADVANCED
Science		<input type="radio"/> BASIC	<input type="radio"/> PROFICIENT	<input type="radio"/> ADVANCED

PARCC Performance-Based Assessments (PBA)				End of Year Assessments (EOY)	
English Language Arts/Literacy	Grade	Score		Score	
Mathematics	Grade	Score		Score	
Algebra I	Grade	Score		Score	
Geometry	Grade	Score		Score	
Algebra II	Grade	Score		Score	

INDIVIDUALIZED EDUCATION PROGRAM (IEP) II. PRESENT LEVEL OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

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Name: _____

Agency: _____

IEP Team Meeting Date: / /

EARLY LEARNING SKILLS:

- Social Foundations
- Language and literacy
- Mathematics
- Science
- Social studies
- Physical well-being and motor development
- Fine arts

Document child's educational and functional performance levels in areas, as appropriate.

Source(s): _____

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

Level of Educational and Functional Performance: (Consider private, state, local school system, and classroom based assessments, as applicable.) _____

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

INDIVIDUALIZED EDUCATION PROGRAM (IEP) II. PRESENT LEVEL OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

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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? <input type="radio"/> YES <input type="radio"/> 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? <input type="radio"/> YES <input type="radio"/> 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? <input type="radio"/> YES <input type="radio"/> 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? <input type="radio"/> YES <input type="radio"/> NO

INDIVIDUALIZED EDUCATION PROGRAM (IEP) II. PRESENT LEVEL OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

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Name: _____ Agency: _____ IEP Team Meeting Date: / /

PRESCHOOL AGED - PRESENT LEVEL OF EDUCATIONAL AND FUNCTIONAL PERFORMANCE

Where does the child spend time?

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Child care center | <input type="checkbox"/> Family Support Center | <input type="checkbox"/> Parent's place of employment | <input type="checkbox"/> Public Pre-K program |
| <input type="checkbox"/> Child's home | <input type="checkbox"/> Home of family member | <input type="checkbox"/> Parks and Recreation program or activities | <input type="checkbox"/> Religious setting |
| <input type="checkbox"/> Early Head Start/Head Start | <input type="checkbox"/> Judy Center | <input type="checkbox"/> Preschool playgroup | <input type="checkbox"/> Shelter |
| <input type="checkbox"/> Family Child Care | <input type="checkbox"/> Library | <input type="checkbox"/> Private Pre-K/Nursery school | <input type="checkbox"/> Other: _____ |

What are parent's concerns and priorities regarding their preschool child's educational and functional performance? _____

How does the child's disability affect his/her access to and participation in age appropriate activities? _____

Consider the child's strengths and needs across three functional areas: **STRENGTHS AND NEEDS SUMMARY**

<p><i>For children to be active and successful participants at home, in the community, and in places like child care or preschool programs, they need to develop skills in three functional areas: (1) developing positive social-emotional skills; (2) acquiring and using knowledge and skills; and (3) taking appropriate action to meet needs. Multiple sources of information are used to understand the child's individual progress in relation to him/herself and to same age peers. These sources include the family's concerns and priorities and the child's educational and functional performance across settings.</i></p> <p>HOW DOES THE CHILD...</p>	<p>CHILD'S STRENGTHS</p> <p>What are some things the child likes to do? What skills does the child demonstrate or is beginning to demonstrate?</p>	<p>CHILD'S NEEDS</p> <p>What are some things or behaviors that the child does not do or are difficult for the child? In what activities or skill areas does the child need considerable support and/or practice?</p>	<p>HOW DOES THE CHILD'S DEVELOPMENT RELATE TO HIS/HER SAME-AGE PEERS?</p> <p>Relative to same age peers: <input type="radio"/> has the skills that we would expect of his/her age in regard to this area. <input type="radio"/> has the skills that we would expect of his/her age in regard to this area; however, there are concerns with this area. <input type="radio"/> shows many age expected skills, but continues to show some functioning that might be described like that of a slightly younger child in this area. <input type="radio"/> shows occasional use of some age expected skills, but more of his/her skills are not yet age expected in this area. <input type="radio"/> is not yet using skills expected of his/her age. He/she does however use many important and immediate foundational skills to build upon in this area. <input type="radio"/> is showing some emerging or immediate foundational skills, which will help him/her to work toward age appropriate skills in this area. <input type="radio"/> functioning might be described as like that of a much younger child. He/she shows early skills, but not yet immediate foundational or age expected skills in this area.</p> <p>Child Outcome Summary (COS): <input type="radio"/> Entry <input type="radio"/> Interim <input type="radio"/> Exit <input type="radio"/> N/A COS Completed Date: _____ Sources: _____ <input type="checkbox"/> Collected without parent input</p>
<p>DEVELOPING POSITIVE SOCIAL-EMOTIONAL SKILLS</p> <ul style="list-style-type: none"> • Relate to family members • Relate to/interact with other adults • Relate to/interact with siblings/other children • Communicate/regulate emotions and feelings • Engage others in social interactions and play • Adapt to changes in routines or settings • Understand and follow social rules 			<p>Choose a rating from the list above: Relative to same age peers - _____</p> <p><i>Only answer if updating the original Strengths and Needs Summary:</i> Has the child shown any new skills or behaviors related to positive social-emotional development since the last Strengths and Needs Summary? <input type="radio"/> Yes <input type="radio"/> No</p>
<p>ACQUIRING AND USING KNOWLEDGE AND SKILLS</p> <ul style="list-style-type: none"> • Communicate (e.g., through sign language, spoken vocabulary, augmentative device, picture symbols) • Use words/skills in everyday settings, including play • Interact with books, pictures, print • Problem solve new situations • Understand pre-academic concepts • Understand and respond to directions 			<p>Choose a rating from the list above: Relative to same age peers - _____</p> <p><i>Only answer if updating the original Strengths and Needs Summary:</i> Has the child shown any new skills or behaviors related to acquiring and using knowledge and skills since the last Strengths and Needs Summary? <input type="radio"/> Yes <input type="radio"/> No</p>
<p>TAKING APPROPRIATE ACTION TO MEET NEEDS</p> <ul style="list-style-type: none"> • Communicate wants and needs • Contribute to his own health and safety • Meet self-care needs (feeding, dressing, toileting) • Respond to delays in getting needs/wants met • Seek help when necessary • Move around to get things 			<p>Choose a rating from the list above: Relative to same age peers - _____</p> <p><i>Only answer if updating the original Strengths and Needs Summary:</i> Has the child shown any new skills or behaviors related to taking actions to meet needs since the last Strengths and Needs Summary? <input type="radio"/> Yes <input type="radio"/> No</p>

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Name:

Agency:

IEP Team Meeting Date: / /

SCHOOL AGED - 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?

Name: _____ Agency: _____ IEP Team Meeting Date: / /

COMMUNICATION (required)

Does the student have special communication needs? YES NO

(If yes, describe the specific needs.) _____

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.

The student needs an AT **device(s)** YES NO

If yes, AT **device(s)** will be addressed through:

- Supplementary Aids, Services, Program Modifications, and Supports
- Instructional and Testing Accommodations

The student needs an AT **service(s)** YES NO

If yes, AT **service(s)** will be addressed through:

- Supplementary Aids, Services, Program Modifications, and Supports
- Related Services
- Instructional and Testing Accommodations

Document basis for decision(s): _____

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): _____

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): _____

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): _____

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): _____

Name: _____

Agency: _____

IEP Team Meeting Date: / /

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

(For information regarding the use of specific accommodations for online testing, please refer to Section 5 of the Maryland Accommodations Manual Issue ID 201206)

1. PRESENTATION ACCOMMODATIONS: ('I' covers all instruction/intervention including Bridge Plan)

Visual Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-A: Large Print	I, A
1-B: Magnification Devices	I, A
1-C: Interpretation/Transliteration for the Deaf and Hard of Hearing	I, A
Tactile Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-D: Braille	I, A
1-E: Tactile Graphics	I, A ¹
Auditory Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-F: Human Reader or Audio Recording for Verbatim Reading of Entire Test	I, A ²
1-G: Human Reader or Audio Recording of Selected Sections of Test	I, A ^{2,4}
1-H: Audio Amplification Devices	I, N/A
1-J: Audio Materials	I, A
Multi-Sensory Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-K: Descriptive/Captioned Video	I, N/A
1-L: Text to Speech Software for Verbatim Reading of Entire Test	I, A ³
1-M: Text to Speech Software for Selected Sections of Test	I, N/A ⁴
1-N: Screen Reading Software	I, N/A
1-O: Visual Cues	I, A
1-P: Notes and Outlines	I, N/A
Other Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-Q: Unique	Determined on a case-by-case basis in consultation with MSDE

¹For State assessments, tactile graphics are provided with the braille tests.

² 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, grade 3 ONLY, which assesses a student's ability to decode printed language. Students in grade 3 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 subscore for standard 1, general reading processes.

³Any text-to-speech software may be used for instruction, but the only text-to-speech software currently allowed and supported by the State for assessment is the Kurzweil™ 3000.

⁴Please note that the human reader and text-to-speech accommodations are not allowable accommodations for Selected Sections of the PARCC assessments.

Document basis for decision:

Name: _____

Agency: _____

IEP Team Meeting Date: / /

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

(For information regarding the use of specific accommodations for online testing, please refer to Section 5 of the Maryland Accommodations Manual Issue ID 201206)

2. RESPONSE ACCOMMODATIONS: ('I' covers all instruction/intervention including Bridge Plan)

Response Accommodations	Conditions for Use In Instruction and Assessment
2-A: Scribe	I, A
2-B: Augmentative Communication System and Speech Generating Devices*	I, A
2-C: Braillewriter	I, A
2-D: Electronic Word Processors	I, A
2-E: Electronic Braille Notetakers	I, A
2-F: Recording Devices	I, A
Materials or Devices Used to Solve or Organize Responses	Conditions for Use In Instruction and Assessment
2-G: Respond on Test Book	I, A
2-H: Monitor Test Response	I, A
2-J: Mathematics Tools and Calculation Devices*	I, A
2-K: Spelling and Grammar Devices*	I, A ⁵
2-L: Visual Organizer	I, A ⁶
2-M: Graphic Organizer	I, A
2-N: Computer Access Tools/Devices/Software*	I, N/A
2-O: Writing Tools/Implements*	I, A
Other Response Accommodations	Conditions for Use In Instruction and Assessment
2-P: Unique	Determined on a case-by-case basis in consultation with MSDE

⁵ Spelling and grammar devices are not permitted to be used on the English High School Assessment.

⁶ Photocopying of secure test materials requires approval by the MSDE 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.

Document basis for decision:

* Provide specific description stating the type of accommodation and how the accommodation will be administered:

Name: _____ Agency: _____ IEP Team Meeting Date: / /

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

(For information regarding the use of specific accommodations for online testing, please refer to Section 5 of the Maryland Accommodations Manual Issue ID 201206)

3. TIMING AND SCHEDULING ACCOMMODATIONS: ('I' covers all instruction/intervention including Bridge Plan)

Timing and Scheduling Accommodations	Conditions for Use In Instruction and Assessment
3-A: Extended Time	I, A
3-B: Multiple or Frequent Breaks	I, A
3-C: Change Schedule or Order of Activities – Extend Over Multiple Days	I, A
3-D: Change Schedule or Order of Activities – Within One Day	I, A
Other Timing and Scheduling Accommodations	Conditions for Use In Instruction and Assessment
3-E: Unique	Determined on a case-by-case basis in consultation with MSDE

Document basis for decision: _____

4. SETTING ACCOMMODATIONS: ('I' covers all instruction/intervention including Bridge Plan)

Setting Accommodations	Conditions for Use In Instruction and Assessment
4-A: Reduce Distractions to the Student	I, A
4-B: Reduce Distractions to Other Students	I, A
4-C: Change Location to Increase Physical Access or to Use Special Equipment – Within School Building	I, A
4-D: Change Location to Increase Physical Access or to Use Special Equipment – Outside School Building	I, A
Other Setting Accommodations	Conditions for Use In Instruction and Assessment
4-E: Unique	Determined on a case-by-case basis in consultation with MSDE

Document basis for decision: _____

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

Document basis for decision: _____

Name: _____

Agency: _____

IEP Team Meeting Date: / /

SUPPLEMENTARY AIDS, SERVICES, PROGRAM MODIFICATIONS AND SUPPORTS

Instructional Support(s)

Nature of Service	Frequency	Begin Date	End Date	Provider(s) Ⓟ = Primary, ○ = Other	
<input type="radio"/> Allow use of highlighters during instruction and assignments <input type="radio"/> Allow use of manipulatives <input type="radio"/> Allow use of organizational aids <input type="radio"/> Check for understanding <input type="radio"/> Frequent and/or immediate feedback <input type="radio"/> Have student repeat and/or paraphrase information <input type="radio"/> Limit amount to be copied from board <input type="radio"/> Monitor independent work <input type="radio"/> Paraphrase questions & instruction <input type="radio"/> Peer tutoring/paired work arrangement <input type="radio"/> Picture schedule	<input type="radio"/> Provide alternative ways for students to demonstrate learning <input type="radio"/> Provide assistance w/ organization <input type="radio"/> Provide home sets of textbooks/materials <input type="radio"/> Provide proofreading checklist <input type="radio"/> Provide student w/ copy of student/teacher notes <input type="radio"/> Repetition of directions <input type="radio"/> Use of word bank to reinforce vocabulary and/or when extended writing is required <input type="radio"/> Other: _____	Anticipated Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Periodically <input type="radio"/> Quarterly <input type="radio"/> Semi-annually <input type="radio"/> Other _____	MM•DD•YYYY MM•DD•YYYY Duration _____ weeks	<input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____ <input type="radio"/> Nurse	<input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant <input type="radio"/> Therapeutic Behavioral Aide

Clarify location and manner: _____

Name: _____

Agency: _____

IEP Team Meeting Date: / /

SUPPLEMENTARY AIDS, SERVICES, PROGRAM MODIFICATIONS AND SUPPORTS

Program Modification(s)

Nature of Service	Frequency	Begin Date	End Date	Provider(s) Ⓟ = Primary, ○ = Other
<input type="radio"/> Altered/modified assignments <input type="radio"/> Break down assignments into smaller units <input type="radio"/> Chunking of text(s) <input type="radio"/> Delete extraneous information on assignments and assessment, when possible <input type="radio"/> Limit amount of required reading <input type="radio"/> Modified content <input type="radio"/> Modified grading system <input type="radio"/> Open book exams <input type="radio"/> Oral exams <input type="radio"/> Reduce number of answer choices <input type="radio"/> Reduced length of exams	<input type="radio"/> Remove "except" and "not" questions, when possible <input type="radio"/> Revise format of test (i.e. fewer questions, fill-in-the-blank) <input type="radio"/> Separate long paragraph questions into bullets, whenever possible <input type="radio"/> Simplified sentence structure, vocabulary, and graphics on assignments and assessments <input type="radio"/> Use pictures to support reading passages, whenever possible <input type="radio"/> Other: _____	Anticipated Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Periodically <input type="radio"/> Quarterly <input type="radio"/> Semi-annually <input type="radio"/> Other _____	MM•DD•YYYY MM•DD•YYYY Duration _____ weeks	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____ <input type="radio"/> Nurse </div> <div style="width: 45%;"> <input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant <input type="radio"/> Therapeutic Behavioral Aide </div> </div>

Clarify location and manner: _____

Name: _____

Agency: _____

IEP Team Meeting Date: / /

SUPPLEMENTARY AIDS, SERVICES, PROGRAM MODIFICATIONS AND SUPPORTS

Social/Behavior Support(s)

Nature of Service	Frequency	Begin Date	End Date	Provider(s) Ⓟ = Primary, ○ = Other	
<input type="radio"/> Adult support <input type="radio"/> Advance preparation for schedule changes <input type="radio"/> Anger management training <input type="radio"/> Check for understanding <input type="radio"/> Crisis intervention <input type="radio"/> Encourage student to ask for assistance when needed <input type="radio"/> Encourage/reinforce appropriate behavior in academic and non academic settings <input type="radio"/> Frequent eye contact/proximity control <input type="radio"/> Frequent reminder of rules <input type="radio"/> Home-school communication system <input type="radio"/> Implementation of behavior contract <input type="radio"/> Monitor use of agenda book and/or progress report	<input type="radio"/> Provide frequent changes in activities or opportunities for movement <input type="radio"/> Provide manipulatives and/or sensory activities to promote listening and focusing skills <input type="radio"/> Provide structured time for organization of materials <input type="radio"/> Reinforce positive behavior through non-verbal/verbal communication <input type="radio"/> Social skills training <input type="radio"/> Strategies to initiate and sustain attention <input type="radio"/> Use of positive/concrete reinforcers <input type="radio"/> Other: _____	Anticipated Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Periodically <input type="radio"/> Quarterly <input type="radio"/> Semi-annually <input type="radio"/> Other _____	MM•DD•YYYY MM•DD•YYYY Duration _____ weeks	<input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____ <input type="radio"/> Nurse	<input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant <input type="radio"/> Therapeutic Behavioral Aide

Clarify location and manner: _____

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

III. SPECIAL CONSIDERATIONS AND ACCOMMODATIONS

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2015)

Name: _____

Agency: _____

IEP Team Meeting Date: ____ / ____ / ____

SUPPLEMENTARY AIDS, SERVICES, PROGRAM MODIFICATIONS AND SUPPORTS

Physical/Environmental Support(s)

Nature of Service	Frequency	Begin Date	End Date	Provider(s) Ⓟ = Primary, ○ = Other	
<input type="radio"/> Access to elevator <input type="radio"/> Adaptive equipment <input type="radio"/> Adaptive feeding devices <input type="radio"/> Adjustments to sensory input (i.e. light, sound) <input type="radio"/> Allow extra time for movement between classes <input type="radio"/> Environmental aids (i.e. classroom acoustics, heating, ventilation)	<input type="radio"/> Preferential locker location <input type="radio"/> Preferential seating <input type="radio"/> Reduce paper/pencil tasks <input type="radio"/> Sensory diet <input type="radio"/> Picture schedule <input type="radio"/> Other: _____	Anticipated Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Periodically <input type="radio"/> Quarterly <input type="radio"/> Semi-annually <input type="radio"/> Other _____	MM•DD•YYYY MM•DD•YYYY Duration _____ weeks	<input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____ <input type="radio"/> Nurse	<input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant <input type="radio"/> Therapeutic Behavioral Aide

Clarify location and manner: _____

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

III. SPECIAL CONSIDERATIONS AND ACCOMMODATIONS

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2015)

Name: _____

Agency: _____

IEP Team Meeting Date: / /

SUPPLEMENTARY AIDS, SERVICES, PROGRAM MODIFICATIONS AND SUPPORTS

School Personnel/Parental Support(s)

Nature of Service		Frequency	Begin Date	End Date	Provider(s) Ⓟ = Primary, ○ = Other	
<input type="radio"/> AT consult <input type="radio"/> Audiologist consult <input type="radio"/> Classroom instruction consult <input type="radio"/> Coordination of support services for crisis prevention and interventions <input type="radio"/> Extracurricular/non academic providers support <input type="radio"/> Occupational therapist consult <input type="radio"/> Orientation and mobility consult	<input type="radio"/> Parent counseling and/or training <input type="radio"/> Physical education consult <input type="radio"/> Physical therapist consult <input type="radio"/> Psychologist consult <input type="radio"/> School health consult <input type="radio"/> Social worker consult <input type="radio"/> Speech/language pathologist consult <input type="radio"/> Travel training <input type="radio"/> Other: _____	Anticipated Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Periodically <input type="radio"/> Quarterly <input type="radio"/> Semi-annually <input type="radio"/> Other _____	MM•DD•YYYY	MM•DD•YYYY Duration _____ weeks	<input type="radio"/> <input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> <input type="radio"/> Speech/Language Pathologist <input type="radio"/> <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> <input type="radio"/> Occupational Therapist <input type="radio"/> <input type="radio"/> Pupil Personnel Worker <input type="radio"/> <input type="radio"/> Physical Education Tchr <input type="radio"/> <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> <input type="radio"/> General Education Tchr <input type="radio"/> <input type="radio"/> Career & Technology Tchr <input type="radio"/> <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> <input type="radio"/> Other Agency _____ <input type="radio"/> <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> <input type="radio"/> Other Service Provider _____ <input type="radio"/> <input type="radio"/> Nurse	<input type="radio"/> <input type="radio"/> Audiologist <input type="radio"/> <input type="radio"/> Psychologist <input type="radio"/> <input type="radio"/> IEP Team <input type="radio"/> <input type="radio"/> Interpreter <input type="radio"/> <input type="radio"/> Instructional Assistant <input type="radio"/> <input type="radio"/> Physical Therapist <input type="radio"/> <input type="radio"/> Home-Based Teacher <input type="radio"/> <input type="radio"/> Guidance Counselor <input type="radio"/> <input type="radio"/> School Social Worker <input type="radio"/> <input type="radio"/> Recreational Therapist <input type="radio"/> <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> <input type="radio"/> Physical Therapy Assistant <input type="radio"/> <input type="radio"/> Speech/Language Assistant <input type="radio"/> <input type="radio"/> Therapeutic Behavioral Aide

Clarify location and manner: _____

Documentation to Support Decision: _____

Supplementary Aids, Services, Program Modifications and Supports were considered and none are required at this time. YES NO

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 is eligible for ESY service.

NO, student is not eligible for 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 assessment(s).

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

Discussion of student's interests, preferences and age appropriate transition assessment(s): _____

POSTSECONDARY GOALS (Outcomes):

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

Employment (required): _____

Training: _____

Education: _____

Independent Living (if appropriate): _____

COURSE OF STUDY:

The student is enrolled in courses that will prepare him/her for a career or postsecondary education in the career cluster selected below.

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

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

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

Discussion to support decision: _____

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 the end of the school year the student turns 21
 - Certificate of Program Completion prior to the end of the school year the student turns 21 (Parent and student choice)

PROJECTED DATE OF EXIT:

The student is participating in a _____ year program and 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 58-412.1, Annotated Code of Maryland? Yes N/A

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: _____

Annual date student and parent were provided a copy of the Transition Planning Guide • • (MM•DD•YYYY)

AGENCY LINKAGE:

*The student has been referred to:

*Agency Representatives were invited to the IEP Team meeting:

Anticipated Services for Transition:

	Yes	No	Yes	No	N/A	Yes	No
Division of Rehabilitation Services (DORS)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developmental Disabilities Administration (DDA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Behavioral Health Administration (BHA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*If no or N/A, document basis for decision: _____

Discussion to support decision: _____

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

IV. GOALS

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2015)

Name: _____ Agency: _____ IEP Team Meeting Date: / /

GOAL _____	
Goal: _____ _____	
By: <input type="text"/> / <input type="text"/> / <input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/> (MM•DD•YYYY)	
Evaluation Method: <input type="checkbox"/> INFORMAL PROCEDURES <input type="checkbox"/> CLASSROOM-BASED ASSESSMENT <input type="checkbox"/> OBSERVATION RECORD <input type="checkbox"/> STANDARDIZED ASSESSMENT <input type="checkbox"/> PORTFOLIO ASSESSMENT <input type="checkbox"/> OTHER _____	
With _____ <input type="checkbox"/> % Accuracy <input type="checkbox"/> % decrease <input type="checkbox"/> ___ out of ___ trials <input type="checkbox"/> % increase <input type="checkbox"/> other _____	
ESY goal? <input type="radio"/> YES <input type="radio"/> NO	
Objective 1: _____ _____ _____	Objective 3: _____ _____ _____
Objective 2: _____ _____ _____	Objective 4: _____ _____ _____
Progress Toward Goal	
Progress Report 1 Date _____	Progress Code: <input type="radio"/> Achieved <input type="radio"/> Making sufficient progress to meet goal <input type="radio"/> Newly introduced skill; progress not measurable at this time <input type="radio"/> Not making sufficient progress to meet the goal <input type="radio"/> Not yet introduced (IEP team needs to meet to address insufficient progress) Description of Progress: _____
Progress Report 2 Date _____	Progress Code: <input type="radio"/> Achieved <input type="radio"/> Making sufficient progress to meet goal <input type="radio"/> Newly introduced skill; progress not measurable at this time <input type="radio"/> Not making sufficient progress to meet the goal <input type="radio"/> Not yet introduced (IEP team needs to meet to address insufficient progress) Description of Progress: _____
Progress Report 3 Date _____	Progress Code: <input type="radio"/> Achieved <input type="radio"/> Making sufficient progress to meet goal <input type="radio"/> Newly introduced skill; progress not measurable at this time <input type="radio"/> Not making sufficient progress to meet the goal <input type="radio"/> Not yet introduced (IEP team needs to meet to address insufficient progress) Description of Progress: _____
Progress Report 4 Date _____	Progress Code: <input type="radio"/> Achieved <input type="radio"/> Making sufficient progress to meet goal <input type="radio"/> Newly introduced skill; progress not measurable at this time <input type="radio"/> Not making sufficient progress to meet the goal <input type="radio"/> Not yet introduced (IEP team needs to meet to address insufficient progress) Description of Progress: _____

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

How often? WEEKLY BI-WEEKLY MONTHLY INTERIM QUARTERLY END OF MARKING PERIOD OTHER _____

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

V. SERVICES

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2015)

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
<input type="radio"/> Classroom Instruction (Identifying the number of sessions for Classroom Instruction is optional) <input type="radio"/> Physical Education <input type="radio"/> Speech/Language Therapy <input type="radio"/> Travel Training	<input type="radio"/> In General Education <input type="radio"/> Outside General Education	Number of Sessions <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> Other _____	Length of Time _____ Hours _____ Minutes	Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Quarterly <input type="radio"/> Semi-annually	MM•DD YYYY	MM•DD YYYY Duration _____ weeks	<input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____	<input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant <input type="radio"/> Therapeutic Behavioral Aide	Total service time: <input type="radio"/> weekly <input type="radio"/> monthly <input type="radio"/> 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
<input type="radio"/> Classroom Instruction (Identifying the number of sessions for Classroom Instruction is optional) <input type="radio"/> Physical Education <input type="radio"/> Speech/Language Therapy <input type="radio"/> Travel Training	<input type="radio"/> In General Education <input type="radio"/> Outside General Education	Number of Sessions <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> Other _____	Length of Time _____ Hours _____ Minutes	Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Quarterly <input type="radio"/> Semi-annually	MM•DD YYYY	MM•DD YYYY Duration _____ weeks	<input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____	<input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant <input type="radio"/> Therapeutic Behavioral Aide	Total service time: <input type="radio"/> weekly <input type="radio"/> monthly <input type="radio"/> yearly _____ Hrs. _____ Min.

Discussion of service(s) delivery: _____

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

V. SERVICES

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2015)

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
<input type="radio"/> Audiological Services <input type="radio"/> Psychological Services <input type="radio"/> Occupational Therapy <input type="radio"/> Physical Therapy <input type="radio"/> Recreation <input type="radio"/> Early Identification & Assessment <input type="radio"/> Counseling Services <input type="radio"/> School Health Services <input type="radio"/> Social Work Services <input type="radio"/> Parent Counseling & Training <input type="radio"/> Rehabilitative Counseling <input type="radio"/> Orientation & Mobility Training Services <input type="radio"/> Assistive Technology Services <input type="radio"/> Medical Services (Diagnostic & Evaluation) <input type="radio"/> Other Therapies _____ <input type="radio"/> Interpreting Services <input type="radio"/> Speech/Language Therapy <input type="radio"/> Nursing Services	<input type="radio"/> In General Education <input type="radio"/> Outside General Education	Number of Sessions <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> Other _____	Length of Time _____ Hours _____ Minutes	Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Quarterly <input type="radio"/> Semi-annually Duration _____ weeks	MM•DD YYYY	MM•DD YYYY Duration _____ weeks	<input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____ <input type="radio"/> Nurse	<input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant <input type="radio"/> Therapeutic Behavioral Aide	Total service time: <input type="radio"/> weekly <input type="radio"/> monthly <input type="radio"/> 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
<input type="radio"/> Audiological Services <input type="radio"/> Psychological Services <input type="radio"/> Occupational Therapy <input type="radio"/> Physical Therapy <input type="radio"/> Recreation <input type="radio"/> Early Identification & Assessment <input type="radio"/> Counseling Services <input type="radio"/> School Health Services <input type="radio"/> Social Work Services <input type="radio"/> Parent Counseling & Training <input type="radio"/> Rehabilitative Counseling <input type="radio"/> Orientation & Mobility Training Services <input type="radio"/> Assistive Technology Services <input type="radio"/> Medical Services (Diagnostic & Evaluation) <input type="radio"/> Other Therapies _____ <input type="radio"/> Interpreting Services <input type="radio"/> Speech/Language Therapy <input type="radio"/> Nursing Services	<input type="radio"/> In General Education <input type="radio"/> Outside General Education	Number of Sessions <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> Other _____	Length of Time _____ Hours _____ Minutes	Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Quarterly <input type="radio"/> Semi-annually Duration _____ weeks	MM•DD YYYY	MM•DD YYYY Duration _____ weeks	<input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____ <input type="radio"/> Nurse	<input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant <input type="radio"/> Therapeutic Behavioral Aide	Total service time: <input type="radio"/> weekly <input type="radio"/> monthly <input type="radio"/> yearly _____ Hrs. _____ Min.

Discussion of service(s) delivery including description of Transportation services if provided: _____

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

V. SERVICES

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2015)

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
<input type="radio"/> Career and Technology Education Program w/ Support Services <input type="radio"/> Vocational Evaluation <input type="radio"/> Special Education Program with Pre-Vocation Objectives	<input type="radio"/> In General Education <input type="radio"/> Outside General Education	Number of Sessions <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> Other _____	Length of Time _____ Hours _____ Minutes	Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Quarterly <input type="radio"/> Semi-annually	MM•DD YYYY	MM•DD YYYY Duration _____ weeks	<input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____	<input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant <input type="radio"/> Therapeutic Behavioral Aide	Total service time: <input type="radio"/> weekly <input type="radio"/> monthly <input type="radio"/> 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
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<input type="radio"/> Career and Technology Education Program w/ Support Services <input type="radio"/> Vocational Evaluation <input type="radio"/> Special Education Program with Pre-Vocation Objectives	<input type="radio"/> In General Education <input type="radio"/> Outside General Education	Number of Sessions <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> Other _____	Length of Time _____ Hours _____ Minutes	Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Quarterly <input type="radio"/> Semi-annually	MM•DD YYYY	MM•DD YYYY Duration _____ weeks	<input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____	<input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant <input type="radio"/> Therapeutic Behavioral Aide	Total service time: <input type="radio"/> weekly <input type="radio"/> monthly <input type="radio"/> yearly _____ Hrs. _____ Min.
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Discussion of service(s) delivery: _____

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 regular early childhood program/general education environment, explain reasons why services cannot be provided in that setting with the use of supplementary aids and services: _____
 Document basis for decision(s): _____

- Special education placement (ages 3-5):
- ATTENDING A REGULAR EARLY CHILDHOOD PROGRAM FOR AT LEAST 10 HOURS PER WEEK AND RECEIVING THE MAJORITY OF SPECIAL EDUCATION AND RELATED SERVICES IN THAT SETTING
 - ATTENDING A REGULAR EARLY CHILDHOOD PROGRAM FOR AT LEAST 10 HOURS PER WEEK AND RECEIVING THE MAJORITY OF SPECIAL EDUCATION AND RELATED SERVICES IN SOME OTHER LOCATION
 - ATTENDING A REGULAR EARLY CHILDHOOD PROGRAM LESS THAN 10 HOURS PER WEEK AND RECEIVING THE MAJORITY OF SPECIAL EDUCATION AND RELATED SERVICES IN THAT SETTING
 - ATTENDING A REGULAR EARLY CHILDHOOD PROGRAM LESS THAN 10 HOURS PER WEEK AND RECEIVING THE MAJORITY OF SPECIAL EDUCATION AND RELATED SERVICES IN SOME OTHER LOCATION
 - SERVICE PROVIDER LOCATION SEPARATE CLASS PRIVATE SEPARATE DAY SCHOOL PRIVATE RESIDENTIAL FACILITY
 - HOME PUBLIC SEPARATE DAY SCHOOL PUBLIC RESIDENTIAL FACILITY
- Special education placement (ages 6-21):
- { 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 }
- Average _____ %/day
- INSIDE GENERAL EDUCATION (80% or more) PUBLIC SEPARATE DAY SCHOOL PRIVATE RESIDENTIAL FACILITY PARENTALLY PLACED IN PRIVATE SCHOOL
 - INSIDE GENERAL EDUCATION (40% - 79%) PRIVATE SEPARATE DAY SCHOOL HOMEBOUND/HOSPITAL
 - INSIDE GENERAL EDUCATION (less than 40%) PUBLIC RESIDENTIAL FACILITY CORRECTIONAL FACILITIES

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): _____

Consideration of Transportation Needs: Is the Related Service Transportation needed based on the unique needs of the student or to allow student access to special education services? YES NO

If yes, consider: _____

Is specialized equipment needed to assist the student during transportation? YES NO If yes, explain: _____

Are personnel needed to accommodate the student during transportation? YES NO If yes, list type(s) of personnel: _____

Are other supports needed to assist the student during transportation? YES NO If yes, explain: _____

Discussion of consideration of age and disability, time and distance involved in travel, and unique needs of the student in determining need for the Related Service Transportation: _____

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.
- (4) Eligible public school student with a disability not receiving services due to parent refusal of initial services.
- (6) Eligible student with a disability prior to age 3. Parent Consent-Continue Early Intervention Services through an IFSP.

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

VII. AUTHORIZATION(S)

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2015)

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. If I revoke consent, in writing, for my child to receive special education services after my child is initially provided special education and related services, the public agency is not required to amend my child's education records to remove any references to my child's receipt of special education and related services because of my revocation of consent.

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:

Name:

Agency:

IEP Team Meeting Date: / /

MEDICAL ASSISTANCE (MA)

Parental consent must be obtained before the provider agency discloses, for billing purposes, their child's personally identifiable information to the Maryland Department of Health and Mental Hygiene (DHMH), the State agency responsible for the administration of the Medical Assistance Program, consistent with the Family Educational Rights and Privacy Act (FERPA) and the Individuals with Disabilities Education Act (IDEA). By providing consent, you understand and agree in writing that the public agency may access your child's Medicaid to pay for services provided to your child.

In order to provide a free appropriate public education (FAPE) to your child, the provider agency may not:

- Require you to sign up for or enroll in State's Medical Assistance in order for your child to receive FAPE under IDEA,
- Require you to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services,
- Use your child's benefits under Medical Assistance if that use would:
 - o Decrease available lifetime coverage or any other insured benefit;
 - o Result in your family paying for services that would otherwise be covered by Medical Assistance and that are required for your child outside of the time your child is in school;
 - o Increase premiums or lead to the discontinuation of benefits or insurance; or
 - o Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

You have the right to withdraw your consent to disclosure of personally identifiable information to State's Medical Assistance Program at any time.

If you withdraw consent for the provider agency to disclose your child's personally identifiable information it does not relieve the provider agency of its responsibility to ensure that all required services are provided to your child at no cost to you.

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 my consent for the provider agency to disclose my child's personally identifiable information to the State's Medical Assistance Program in order to access Medical Assistance Benefits.

I give permission to the provider agency 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 provider agency access to MA funds, it does not relieve the provider 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 MA benefits. I also understand that my child may not receive a similar type of case management service under MA if he/she qualifies for more than one type.

Parent Signature:

Date:
