

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, 2010)

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

EXISTING RACE CODES	NEW RACE CODES
<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black or African American (not Hispanic)	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White (not Hispanic)	<input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White
	Ethnicity: Hispanic or Latino <input type="checkbox"/> Yes <input type="checkbox"/> No

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: _____

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 HEARING IMPAIRMENT SPEECH OR LANGUAGE IMPAIRMENT
 DEAF INTELLECTUAL DISABILITY TRAUMATIC BRAIN INJURY
 DEAF - BLINDNESS ORTHOPEDIC IMPAIRMENT VISUAL IMPAIRMENT
 DEVELOPMENTAL DELAY OTHER HEALTH IMPAIRMENT MULTIPLE DISABILITIES
 EMOTIONAL DISABILITY SPECIFIC LEARNING DISABILITY 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)

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: Transition C to B

- Eligibility not determined due to withdrawal of consent, moved from district, child unavailable as a result of chronic condition or illness.
 Initial evaluation prior to age 3
 If evaluation for child prior to age 3 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
 Other:
 Inclement weather Staffing issues
 Paperwork error Other, please specify: _____
 Inconclusive testing results

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

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

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)
 Extended IFSP services ended at kindergarten age:

 (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: School Age (3-21)

- Eligibility not determined due to withdrawal, i.e., transfer, dropout, parent withdrew consent.
 Initial evaluation for student ages 3-21
 If evaluation for student ages 3-21 was delayed, indicate reason(s) for delay:
 Parent repeatedly failed or refused to make the child available
 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)
 Parent requested delay - Parent and IEP team extend the timeframe by mutual written agreement
 School/facility closure
 Other:
 Inclement weather Child not available (not parent failure)/child refusal
 Paperwork error Staffing issues
 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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Agency: _____

IEP Team Meeting Date: / /

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) _____ |

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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

Student is pursuing a:

Maryland High School Diploma Maryland High School Certificate of Program Completion

The student is officially identified as a ninth grade student effective in the academic school year (YYYY) - (YYYY).

The student was originally identified as participating in a
 4 year 5 year 6 year plan.

The student is currently participating in a 4 year 5 year 6 year plan.

Will the student participate in the Maryland School Assessment aligned with grade level academic achievement standards in assessed grade? (MSA-Grades 3-8)
 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-Grades 3-8)
 Reading YES NO Math YES NO Science YES NO

Will the student participate in the Maryland High School Assessment aligned with Core Learning Goals in assessed course? (HSA)
 Algebra/Data Analysis YES NO English YES NO
 Biology YES NO Government YES NO

Will the student participate in the Maryland High School Assessment aligned with Core Learning Goals/modified achievement standards in assessed course? (Mod-HSA)
 Algebra/Data Analysis YES NO English YES NO
 Biology YES NO Government YES NO

Will the student participate in Alternate Maryland School Assessment aligned with alternate academic/course achievement standards in reading, math and science in assessed grade? (Alt-MSA) YES NO

Document basis for decision(s): _____

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

PERFORMANCE SUMMARY

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

(MM•DD•YYYY)

FULL APPROACHING DEVELOPING

Is the student limited English proficient? YES NO

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

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

MSA Assessments Scale Score (Check Mod, if appropriate.)

Reading	<input type="checkbox"/> Mod	<input type="text"/>	<input type="radio"/> BASIC	<input type="radio"/> PROFICIENT	<input type="radio"/> ADVANCED
Math	<input type="checkbox"/> Mod	<input type="text"/>	<input type="radio"/> BASIC	<input type="radio"/> PROFICIENT	<input type="radio"/> ADVANCED
Science	<input type="checkbox"/> Mod	<input type="text"/>	<input type="radio"/> BASIC	<input type="radio"/> PROFICIENT	<input type="radio"/> ADVANCED

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

(MM•DD•YYYY)?

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	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

What was the student's performance, if applicable, on Alt-MSA as of

(MM•DD•YYYY)?

Alt-MSA Assessments % of Mastery Objectives

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

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

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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

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

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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?

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

Document basis for decision(s): _____

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

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

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 (Prior Code: III-A)	I, A
1-B: Magnification Devices (Prior Code: N/A, none)	I, A
1-C: Interpretation/Transliteration for the Deaf and Hard of Hearing (Prior Code: IV-D)	I, A
Tactile Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-D: Braille (Prior Code: III-B)	I, A
1-E: Tactile Graphics (Prior Code: N/A, none) NOTE: For purposes of State assessments, any tactile graphics needed are included with the Braille version of the test.	I, A
Auditory Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-F: Human Reader, Audio Tape, or Compact Disk Recording for Verbatim Reading of Entire Test (Prior Codes: IV-F, IV-H)	I, A*
1-G: Human Reader, Audio Tape, or Compact Disk Recording for Verbatim Reading of Selected Sections of Test (Prior Codes: IV-G, IV-I)	I, A*
1-H: Audio Amplification Devices (Prior Code: IV-D)	I, A
1-J: Books on Tape (Prior Code: III-C)	I, N/A
1-K: Recorded Books (Prior Code: III-C)	I, N/A
Multi-Sensory Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-L: Video Tape and Descriptive Video (Prior Code: N/A, none) NOTE: No Maryland assessments currently incorporate video-taped stimulus materials. However, if video tape is used, students must have access to closed captioning on video materials, as appropriate.	I, N/A
1-M: Screen Reader for Verbatim Reading of Entire Test (Prior Codes: IV-F, IV-H)	I, A*
1-N: Screen Reader for Verbatim Reading of Selected Sections of Test (Prior Codes: IV-G, IV-I)	I, A*
1-O: Visual Cues (Prior Code: N/A)	I, A
1-P: Notes, Outlines, and Instructions (Prior Code: N/A, none)	I, N/A
1-Q: Talking Materials (Prior Code: III-C)	I, A
Other Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-R: Other (Prior Code: IV-J)	Determined on a case-by-case basis in consultation with MSDE

* Use of the verbatim reading accommodation is permitted on all assessments as a standard accommodation, with the exception of:

(1) the Maryland School Assessment (MSA) in reading, grade 3 only, which assess 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 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.

Discussion to support decision: _____

Name: _____

Agency: _____

IEP Team Meeting Date: / /

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

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

Response Accommodations	Conditions for Use In Instruction and Assessment
2-A: Scribe (Prior Codes: V-B, V-E)	I, A
2-B: Speech-to-Text (Prior Codes: III-D, III-E)	I, A
2-C: Large-Print Response Book (Prior Code: III-A)	I, A
2-D: Braille (Prior Code: III-B)	I, A
2-E: Electronic Note-Takers and Word Processors (Prior Code: N/A, none)	I, A
2-F: Tape Recorder (Prior Code: V-C)	I, A
2-G: Respond on Test Booklet (Prior Code: V-A)	I, A
2-H: Monitor Test Response (Prior Code: V-D)	I, A
Materials or Devices Used to Solve or Organize Responses	Conditions for Use In Instruction and Assessment
2-J: Calculation Devices (Prior Code: III-C)	I, A
2-K: Spelling and Grammar Devices (Prior Code: III-D)	I, A*
2-L: Visual Organizers (Prior Code: N/A, none)	I, A**
2-M: Graphic Organizers (Prior Code: N/A, none)	I, A
2-N: Bilingual Dictionaries (Prior Code: III-F)	I, A
Other Response Accommodations	Conditions for Use In Instruction and Assessment
2-O: Other (Prior Code: V-J)	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.

Discussion to support decision: _____

Name: _____

Agency: _____

IEP Team Meeting Date: / /

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

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

Discussion to support 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 (Prior Codes: II-A, II-B, II-E, II-F)	I, A
4-B: Reduce Distractions to Other Students (Prior Code: II-G)	I, A
4-C: Change Location to Increase Physical Access or to Use Special Equipment – Within School Building (Prior Codes: II-C, II-D)	I, A
4-D: Change Location to Increase Physical Access or to Use Special Equipment – Outside School Building (Prior Code: II-I)	I, A
Other Setting Accommodations	Conditions for Use In Instruction and Assessment
4-E: Other (Prior Code: I-E)	Determined on a case-by-case basis in consultation with MSDE

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

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

Clarify location and manner: _____

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, 2010)

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	<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

Clarify location and manner: _____

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, 2010)

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

Clarify location and manner: _____

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, 2010)

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

Clarify location and manner: _____

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, 2010)

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"/> 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

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 assessments.

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

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

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

- | | | |
|---|--|--|
| <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

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 §8-412.1, Annotated Code of Maryland? Yes N/A

AGENCY LINKAGE:

If appropriate, was the student referred to the appropriate agency for transition and/or post secondary services and a representative from that agency invited to the IEP Team meeting, at which post school outcomes were discussed? Yes N/A

- 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.

Developmental Disabilities Administration (DDA)

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

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.

Mental Hygiene Administration (MHA)

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

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

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, 2010)

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 2: _____ _____ _____	Objective 3: _____ _____ _____ 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"/> Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) <input type="radio"/> Not yet introduced
Description: _____	
Progress Report 2 Date _____	Progress Code: <input type="radio"/> Achieved <input type="radio"/> Making sufficient progress to meet goal <input type="radio"/> Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) <input type="radio"/> Not yet introduced
Description: _____	
Progress Report 3 Date _____	Progress Code: <input type="radio"/> Achieved <input type="radio"/> Making sufficient progress to meet goal <input type="radio"/> Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) <input type="radio"/> Not yet introduced
Description: _____	
Progress Report 4 Date _____	Progress Code: <input type="radio"/> Achieved <input type="radio"/> Making sufficient progress to meet goal <input type="radio"/> Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) <input type="radio"/> Not yet introduced
Description: _____	
Progress Report 5 Date _____	Progress Code: <input type="radio"/> Achieved <input type="radio"/> Making sufficient progress to meet goal <input type="radio"/> Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) <input type="radio"/> Not yet introduced
Description: _____	
How will the parent be notified of the student's progress toward the IEP goals? _____	
How often? <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> INTERIM <input type="checkbox"/> QUARTERLY <input type="checkbox"/> END OF MARKING PERIOD <input type="checkbox"/> 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, 2010)

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 (Select the length of time, in 15 minute increments, that the service is provided during each session) <input type="radio"/> 15 Min. <input type="radio"/> 30 Min. <input type="radio"/> 45 Min. <input type="radio"/> 1 Hr. <input type="radio"/> 1 Hr. 15 Min. <input type="radio"/> 1 Hr. 30 Min. <input type="radio"/> 2 Hrs. <input type="radio"/> 3 Hrs. <input type="radio"/> Other _____	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	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 (Select the length of time, in 15 minute increments, that the service is provided during each session) <input type="radio"/> 15 Min. <input type="radio"/> 30 Min. <input type="radio"/> 45 Min. <input type="radio"/> 1 Hr. <input type="radio"/> 1 Hr. 15 Min. <input type="radio"/> 1 Hr. 30 Min. <input type="radio"/> 2 Hrs. <input type="radio"/> 3 Hrs. <input type="radio"/> Other _____	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	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, 2010)

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 (Select the length of time, in 15 minute increments, that the service is provided during each session) <input type="radio"/> 15 Min. <input type="radio"/> 30 Min. <input type="radio"/> 45 Min. <input type="radio"/> 1 Hr. <input type="radio"/> 1 Hr. 15 Min. <input type="radio"/> 1 Hr. 30 Min. <input type="radio"/> 2 Hrs. <input type="radio"/> 3 Hrs. <input type="radio"/> Other _____	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 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	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 (Select the length of time, in 15 minute increments, that the service is provided during each session) <input type="radio"/> 15 Min. <input type="radio"/> 30 Min. <input type="radio"/> 45 Min. <input type="radio"/> 1 Hr. <input type="radio"/> 1 Hr. 15 Min. <input type="radio"/> 1 Hr. 30 Min. <input type="radio"/> 2 Hrs. <input type="radio"/> 3 Hrs. <input type="radio"/> Other _____	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 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	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, 2010)

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 (Select the length of time, in 15 minute increments, that the service is provided during each session) <input type="radio"/> 15 Min. <input type="radio"/> 30 Min. <input type="radio"/> 45 Min. <input type="radio"/> 1 Hr. <input type="radio"/> 1 Hr. 15 Min. <input type="radio"/> 1 Hr. 30 Min. <input type="radio"/> 2 Hrs. <input type="radio"/> 3 Hrs. <input type="radio"/> Other _____	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	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"/> 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 (Select the length of time, in 15 minute increments, that the service is provided during each session) <input type="radio"/> 15 Min. <input type="radio"/> 30 Min. <input type="radio"/> 45 Min. <input type="radio"/> 1 Hr. <input type="radio"/> 1 Hr. 15 Min. <input type="radio"/> 1 Hr. 30 Min. <input type="radio"/> 2 Hrs. <input type="radio"/> 3 Hrs. <input type="radio"/> Other _____	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	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)

VI. PLACEMENT DATA

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2010)

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.
- (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, 2010)

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: _____

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 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.

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: _____