INDIVIDUALIZED EDUCATION PROGRAM (IEP)

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF EARLY INTERVENTION AND SPECIAL EDUCATION SERVICES

Student Information

(Form approved by MSDE for use July 1, 2023)

◯ 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
□ Asian
□ White
□ Native Hawaiian or other Pacific Islander
□ Black or African American

Student identified as an English Learner: ◯ YES ◯ NO

Student's native language: _____

Residence County: _____

Residence School: _____

Service County: _____

Service School:_____

Does the student requires a specific accommodation for an emergency evacuation? ◯ YES ◯ NO

If yes, state the evacuation accommodation(s) here: _____

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 habilitative services, including a copy of the Maryland Insurance Administration's Parents' Guide to Habilitative Services.

Native Language Translation: Parent informed ◯ YES ◯ NO ◯ N/A Parent requested ◯ YES ◯ NO

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 (Is this student home schooled? ◯ YES ◯ NO)
◯ 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: _____
IEP Chair: _____
Parent/Guardian:_____
Parent/Guardian:_____

Principal/Designee: _____
General Educator: _____
Special Educator:_____
Guidance Counselor: _____

School Psychologist: _____
Social Worker: _____
Speech/Language Pathologist:_____
Student: _____

Agency Representative: _____
Others in attendance:_____
Others in attendance:_____
Others in attendance:_____

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) a lack of instruction in math? ◯ YES ◯ NO

c) a lack of 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)

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

Date of initial evaluation: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

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 ◯ SPEECH OR LANGUAGE IMPAIRMENT ◯ VISUAL IMPAIRMENT

◯ DEAF ◯ EMOTIONAL DISABILITY ◯ ORTHOPEDIC IMPAIRMENT ◯ Dyslexia ◯ Dysgraphia ◯ TRAUMATIC BRAIN INJURY ◯ MULTIPLE DISABILITIES

◯ DEAF - BLINDNESS ◯ HEARING IMPAIRMENT ◯ OTHER HEALTH IMPAIRMENT ◯ Dyscalculia ◯ Other _____ ◯ Cognitive (specify) _____

◯ Sensory (specify _____

Document basis for decision(s): _____ ◯ Physical (specify) _____

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.

Name: Agency: IEP Team Meeting Date: / /

Initial Eligibility (Student Ages 3-21)

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

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

Indicate primary disability

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

Document basis for decision(s): _____

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:

◯ 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
◯ Inclement weather
◯ Other
  ◯ Paperwork error ◯ Child not available (not parent failure)/child refusal
  ◯ Inconclusive testing results ◯ Staffing issues
  ◯ 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

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

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STUDENT PARTICIPATION ON DISTRICT/STATEWIDE ASSESSMENTS AND GRADUATION INFORMATION

Graduation requirements explained to parents ◯ YES ◯ NO

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

Record any additional local graduation requirements: _____

PROJECTED CATEGORY OF EXIT:

The student will exit with: ◯ Maryland High School Diploma

(Choose all that apply)

☐ with 2 credits of World Language, which may include American Sign Language
☐ with 2 credits of Advanced Technology
☐ with successful completion of a State-approved career and technical education 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)

At exit the student will receive a Maryland Summary of Performance (MSOP) that includes academic achievement, functional performance, accommodations, and progress on postsecondary goals.

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

PLAN FOR PARTICIPATION IN THE MARYLAND COMPREHENSIVE ASSESSMENT PROGRAM (MCAP) TO BE ADMINISTERED DURING THE TERM OF THE CURRENT IEP

The student will participate in the **Maryland Comprehensive Assessment Program (MCAP) Assessments** for grades 3 through 8

English Language Arts/Literacy ◯ YES ◯ NO Mathematics ◯ YES ◯ NO Social Studies (Grade 8 only) ◯ YES ◯ NO

The student will participate in the **Maryland Comprehensive Assessment Program (MCAP) Assessments** for high school

English Language Arts/Literacy ◯ YES ◯ NO Algebra ◯ YES ◯ NO Algebra II ◯ YES ◯ NO Geometry ◯ YES ◯ NO Science ◯ YES ◯ NO Government ◯ YES ◯ NO

The student will participate in the **Maryland Integrated Science Assessment (MISA)** aligned with Next Generation Science Standards (NGSS) in assessed grade - (Grades 5, 8) ◯ YES ◯ NO

The student will participate in the **High School Maryland Integrated Science Assessment (MISA)** aligned with Next Generation Science Standards (NGSS) in assessed grade ◯ YES ◯ NO

Has the IEP team determined that the student should participate in an alternate assessment based on alternate academic achievement standards?
(Complete the required Appendix A of the *Guidance for IEP Teams: Participation Decisions for the Alternate Assessments and Instruction Using Alternate Standards* document annually and file in the student's electronic IEP folder.)

◯ YES ◯ NO

Does the parent consent to the student participating in an **alternate assessment** based on alternate academic achievement standards in assessed grade in

•English Language Arts (Grades 3-8, 11) •Mathematics (Grades 3-8, 11) •Science (Grades 5, 8, 11 only) ?

◯ YES - Date of written consent: ☐☐•☐☐•☐☐☐☐ ◯ NO - Date of written refusal: ☐☐•☐☐•☐☐☐☐

◯ No response received within 15 business days of the IEP team meeting date

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STUDENT PARTICIPATION ON DISTRICT/STATEWIDE ASSESSMENTS AND GRADUATION INFORMATION

PLAN FOR PARTICIPATION IN INSTRUCTION USING ALTERNATE STANDARDS

Has the IEP team determined that the student will be **instructed using alternate standards**, which, if continued, will result in not earning credits toward a Maryland High School Diploma? (Complete the required Appendix A of the *Guidance for IEP Teams: Participation Decisions for the Alternate Assessments and Instruction Using Alternate Standards* document annually and file in the student's electronic IEP folder.)

◯ YES ◯ NO

Does the parent consent to the student being instructed using alternate standards?

◯ YES - Date of written consent: ☐☐•☐☐•☐☐☐☐ ◯ NO - Date of written refusal: ☐☐•☐☐•☐☐☐☐

◯ No response received within 15 business days of the IEP team meeting date

Document basis for assessment decision(s): : _____

_____

_____

Student is pursuing a: ◯ Maryland High School Diploma ◯ Maryland High School Certificate of Program Completion

PLEASE NOTE: 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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ENGLISH LANGUAGE PROFICIENCY SUMMARY

Is the student an English Learner? ◯ YES ◯ NO

What was the student's performance on the English language proficiency assessment?

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

Overall Composite Proficiency Level _____

◯ ENTERING ◯ EMERGING ◯ DEVELOPING ◯ EXPANDING ◯ BRIDGING ◯ REACHING

OR

What was the student's performance on the **alternate** English language proficiency assessment?

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

Overall Composite Proficiency Level _____

◯ INITIATING ◯ EXPLORING ◯ ENGAGING ◯ ENTERING ◯ EMERGING

STATEWIDE MARYLAND COMPREHENSIVE ASSESSMENT PROGRAM (MCAP) PERFORMANCE SUMMARY

What was the student's performance, if applicable on the **Kindergarten Readiness Assessment (KRA)** as of ☐☐•☐☐•☐☐☐☐?

Overall Performance	◯ EMERGING ◯ APPROACHING ◯ DEMONSTRATING ◯ OTHER (one or more assessment items not accessible due to disability, resulting in a Not Scorable rating) ◯ INCOMPLETE ASSESSMENT (some or all items were not complete)	**Domain Level Performance**	**Score**	**Range**
		Language and Literacy		202-298
		Mathematics		202-298
		Social Foundations		202-298
Overall Score	_____ (Range: 202-298)	Physical Well-Being and Motor Development		202-293

What was the student's performance on the Grades 3-8 MCAP assessments as of ☐☐•☐☐•☐☐☐☐?

	Current Scale Score		**Last Year's Scale Score**		**Most Current Proficiency Levels**			
MCAP	**Grade**	**Scale Score**	**Grade**	**Scale Score**	**Level 1 Beginning Learner**	**Level 2 Developing Learner**	**Level 3 Proficient Learner**	**Level 4 Distinguished Learner**
English Language Arts					◯	◯	◯	◯
Mathematics					◯	◯	◯	◯
Algebra I, as applicable					◯	◯	◯	◯
Social Studies (Grade 8)					◯	◯	◯	◯
MISA	**Grade**	**Scale Score**	**Grade**	**Scale Score**	**Level 1 Beginning Learner**	**Level 2 Developing Learner**	**Level 3 Proficient Learner**	**Level 4 Distinguished Learner**
Science (Grades 5, 8 only)					◯	◯	◯	◯

What was the student's performance on the High School **MCAP** assessments as of ☐☐•☐☐•☐☐☐☐?

MCAP	**Most Current Scale Score**	**Previous Scale Score**	**Most Current Proficiency Level**			
			Level 1 Beginning Learner	**Level 2 Developing Learner**	**Level 3 Proficient Learner**	**Level 4 Distinguished Learner**
ELA/Literacy (Grade 10)			◯	◯	◯	◯
Algebra			◯	◯	◯	◯
Algebra II			◯	◯	◯	◯
Geometry			◯	◯	◯	◯
Science			◯	◯	◯	◯
Government			◯	◯	◯	◯

What was the student's performance, if applicable, on **alternate assessments** as of ☐☐•☐☐•☐☐☐☐?

	Most Current Proficiency Levels			
DLM	**Level 1 Emerging**	**Level 2 Approaching Target**	**Level 3 At Target**	**Level 4 Advanced**
English Language Arts	◯	◯	◯	◯
Mathematics	◯	◯	◯	◯
Science (Grades 5, 8, 11 only)	◯	◯	◯	◯

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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): _____

_____

_____

Level of Educational and Functional Performance: (Consider multiple data sources including: individualized assessment results, classroom based assessments, district assessments, classroom based observations, parent information, student input and general education teacher input in relevant areas.)_____

_____

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

_____

_____

_____

_____

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

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ACADEMIC _____

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

Source(s): _____

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

_____

Current Instructional Grade Level Performance: _____

(Consider multiple data sources including: individualized assessment results, classroom based assessments, district assessments, classroom based observations, parent information, student input and general education teacher input in relevant areas.)

Instructional Grade Level Performance Trend Data (document the student's rate of growth over the past two years):

School Year	Instructional Grade Level Performance

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

HEALTH _____

Source(s): _____

Level of Performance: _____

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

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

_____

_____

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

PHYSICAL _____

Source(s): _____

Level of Performance: _____

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

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

_____

_____

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

BEHAVIORAL _____

Source(s): _____

Level of Performance: _____

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

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

_____

_____

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

Name: Agency: IEP Team Meeting Date: / /

SECONDARY TRANSITION:

- ◯ Employment
- ◯ Education/Training
- ◯ Independent Living
- ◯ Self-Determination
- ◯ Travel Skills

Employment and Education/Training must be completed for students who will be 14 or older during the period the IEP is active.

Source(s):_____

_____

_____

Current Level of Performance (as appropriate): _____

_____

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

_____

_____

_____

_____

_____

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PRESCHOOL AGED - PRESENT LEVEL OF EDUCATIONAL AND FUNCTIONAL PERFORMANCE

Where does the child spend time?

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

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

_____

How does the child's disability affects 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

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 & relationships; (2) acquiring and using knowledge and skills; and (3) using appropriate behaviors 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. **HOW DOES THE CHILD...**	**CHILD'S STRENGTHS** What are some things the child likes to do? What skills does the child demonstrate or is beginning to demonstrate?	**CHILD'S NEEDS** 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?	**HOW DOES THE CHILD'S DEVELOPMENT RELATE TO HIS/HER SAME-AGE PEERS?** Relative to same age peers: ○ has the skills that we would expect of his/her age in regard to this area. ○ has the skills that we would expect of his/her age in regard to this area; however, there are concerns with this area. ○ 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. ○ shows occasional use of some age expected skills, but more of his/her skills are not yet age expected in this area. ○ 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. ○ is showing some emerging or immediate foundational skills, which will help him/her to work toward age appropriate skills in this area. ○ 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. Child Outcome Summary (COS): ○ Entry ○ Interim ○ Exit ○ N/A COS Completed Date: _____ Sources: _____ □ Collected without parent input
DEVELOPING POSITIVE SOCIAL-EMOTIONAL SKILLS & RELATIONSHIPS • 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			*Choose a rating from the list above:* Relative to same age peers - _____ *Only answer if updating the original Strengths and Needs Summary:* Has the child shown any new skills or behaviors related to positive social-emotional development and relationships since the last Strengths and Needs Summary? ○ Yes ○ No
ACQUIRING AND USING KNOWLEDGE AND SKILLS • 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			*Choose a rating from the list above:* Relative to same age peers - _____ *Only answer if updating the original Strengths and Needs Summary:* Has the child shown any new skills or behaviors related to acquiring and using knowledge and skills since the last Strengths and Needs Summary? ○ Yes ○ No
USING APPROPRIATE BEHAVIORS TO MEET NEEDS • 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			*Choose a rating from the list above:* Relative to same age peers - _____ *Only answer if updating the original Strengths and Needs Summary:* Has the child shown any new skills or behaviors related to using appropriate behaviors to meet needs since the last Strengths and Needs Summary? ○ Yes ○ No

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? (Including academic, functional, social/emotional, behavioral, and secondary transition)

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: / /

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

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

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

Summary of student's preferences, interests, and skills based on age appropriate transition assessment(s): _____

_____

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

EMPLOYMENT (required): _____

_____

Related IEP Goal(s) that will support this postsecondary Employment goal will populate from Annual IEP Goals section here.

Secondary Transition Activities related to Employment, Responsible Party, IEP Planning for Emergency Conditions, and Progress will populate here.

EDUCATION: _____

_____

Related IEP Goal(s) that will support this postsecondary Education goal will populate from Annual IEP Goals section here.

Secondary Transition Activities related to Education, Responsible Party, IEP Planning for Emergency Conditions, and Progress will populate here.

TRAINING: _____

_____

Related IEP Goal(s) that will support this postsecondary Training goal will populate from Annual IEP Goals section here.

Secondary Transition Activities related to Training, Responsible Party, IEP Planning for Emergency Conditions, and Progress will populate here.

INDEPENDENT LIVING (if appropriate): _____

_____

Related IEP Goal(s) that will support this postsecondary Independent Living goal will populate from Annual IEP Goals section here.

Secondary Transition Activities related to Independent Living, Responsible Party, IEP Planning for Emergency Conditions, and Progress will populate here.

Name: Agency: IEP Team Meeting Date: / /

SECONDARY 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 progression from school to postsecondary activities.

ACTIVITY TYPE: ◯ EMPLOYMENT ◯ ACADEMIC ◯ ACTIVITIES OF DAILY LIVING ◯ INDEPENDENT LIVING ◯ TRANSPORTATION

_____

_____

_____

Responsible Party: _____

Identify the postsecondary goal that this activity supports (Services/Activities added here will populate in the IEP below the corresponding postsecondary goal):

◯ Employment ◯ Education ◯ Training ◯ Independent Living

IEP Planning for Emergency Conditions:

Can this secondary transition activity be implemented as written during emergency conditions resulting in the physical closure of school for 10 or more days?

◯ YES ◯ NO If no, describe the changes needed to this secondary transition activity: _____

Progress Report 1 Date_____	Progress: ◯ Completed ◯ Partially Completed ◯ Not Yet Initiated ◯ Not Completed (Reason: ◯ Family Choice ◯ Student Choice ◯ Student's Schedule ◯ Other: _____) Employment Activity Involved *(for EMPLOYMENT activities only)*: ◯ Career Exploration ◯ Unpaid Work Experience ◯ Paid Work Experience Description of Progress: _____
Progress Report 2 Date_____	Progress: ◯ Completed ◯ Partially Completed ◯ Not Yet Initiated ◯ Not Completed (Reason: ◯ Family Choice ◯ Student Choice ◯ Student's Schedule ◯ Other: _____) Employment Activity Involved *(for EMPLOYMENT activities only)*: ◯ Career Exploration ◯ Unpaid Work Experience ◯ Paid Work Experience Description of Progress: _____
Progress Report 3 Date_____	Progress: ◯ Completed ◯ Partially Completed ◯ Not Yet Initiated ◯ Not Completed (Reason: ◯ Family Choice ◯ Student Choice ◯ Student's Schedule ◯ Other: _____) Employment Activity Involved *(for EMPLOYMENT activities only)*: ◯ Career Exploration ◯ Unpaid Work Experience ◯ Paid Work Experience Description of Progress: _____
Progress Report 4 Date_____	Progress: ◯ Completed ◯ Partially Completed ◯ Not Yet Initiated ◯ Not Completed (Reason: ◯ Family Choice ◯ Student Choice ◯ Student's Schedule ◯ Other: _____) Employment Activity Involved *(for EMPLOYMENT activities only)*: ◯ Career Exploration ◯ Unpaid Work Experience ◯ Paid Work Experience Description of Progress: _____

Name: Agency: IEP Team Meeting Date: / /

SECONDARY TRANSITION/COURSE OF STUDY

COURSE OF STUDY:

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

◯ Arts, Media, and Communications
◯ Business Management and Finance
◯ Construction and Development
◯ Consumer Services, Hospitality, and Tourism
◯ Environmental, Agricultural, and Natural Resources
◯ Health and Biosciences
◯ Human Resources Services
◯ Information Technology
◯ Manufacturing, Engineering, and Technology
◯ Transportation Technologies

Discussion to support decision: _____

_____

List the courses the student is taking that align with their Postsecondary Goals: _____

_____

Name: Agency: IEP Team Meeting Date: / /

SECONDARY TRANSITION AGENCY LINKAGE

AGENCY LINKAGE:

Annual date student and parent were provided a copy of the *A Family Guide to Secondary Transition Planning in Maryland* ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

Adult Service Agency	Anticipated Services for Transition:	Signed Consent for Communication:	Signed Consent for Referral / Student referred by the LSS to:	Signed Consent to invite Agency Representative(s) to IEP Team meeting:	Agency Representative(s) invited to the IEP Team meeting:
Division of Rehabilitation Services (DORS) ☐ Receiving Pre-Employment Transition Services	◯ Yes, Vocational Rehabilitation (VR) ◯ No	◯ Yes: Date _____ ◯ No: (select reason from options below)	◯ Yes: Consent Date _____ Referral Date _____ ◯ No: (select reason from options below)	◯ Yes: Date _____ ◯ No: (select reason from options below)	◯ Yes: Date _____ ◯ No ◯ N/A: (select reason from options below)
Developmental Disabilities Administration (DDA)	◯ Yes ◯ No	◯ Yes: Date _____ ◯ No: (select reason from options below)	Agency does Not have a referral process	◯ Yes: Date _____ ◯ No: (select reason from options below)	◯ Yes: Date _____ ◯ No ◯ N/A: (select reason from options below)
Behavioral Health Administration (BHA)	◯ Yes ◯ No	◯ Yes: Date _____ ◯ No: (select reason from options below)	Agency does Not have a referral process	◯ Yes: Date _____ ◯ No: (select reason from options below)	◯ Yes: Date _____ ◯ No ◯ N/A: (select reason from options below)
Division of Workforce Development & Adult Learning Maryland Department of Labor (MDL)	◯ Yes ◯ No	◯ Yes: Date _____ ◯ No: (select reason from options below)	Agency does Not have a referral process	◯ Yes: Date _____ ◯ No: (select reason from options below)	◯ Yes: Date _____ ◯ No ◯ N/A: (select reason from options below)
Reasons for Decisions	**Yes:** Student meets the initial eligibility criteria for the agency published in the *Maryland Transition Planning Guide for Individuals with Disabilities* **No:** Student does not meet the initial eligibility criteria for the agency published in the *Maryland Transition Planning Guide for Individuals with Disabilities* (select reason ***Services are not anticipated for this student*** for all remaining columns for the agency)	**Yes:** Consent to communicate with agency signed on _____ (date). **No:** (reasons) 1. ***Services are not anticipated for this student*** 2. Student is not the correct age/grade to refer to DORS **(DORS only)** 3. Student is not interested in agency services at this time 4. Parent(s)/Student did not return the Consent for Communication/Referral form, so referral was not made 5. Parent(s)/Student did not give consent on the Consent for Communication/Referral form 6. Parent(s)/Student have chosen to self-refer to DORS **(DORS only)** 7. Other: _____ (document reason)	**Yes:** Consent for Referral signed on _____ (date) and Student was referred to DORS on _____ (date) **No:** (reasons) 1. ***Services are not anticipated for this student*** 2. Student is not the correct age/grade to refer to DORS 3. Student is not interested in DORS services at this time 4. Parent(s)/Student did not return the Consent for Communication/Referral form, so referral was not made 5. Parent(s)/Student did not give consent on the Consent for Communication/Referral form 6. Parent(s)/Student have chosen to self-refer 7. Other: _____ (document reason)	**Yes:** Signed Consent to invite Agency Representative to IEP Team meeting signed on _____ (date) **No:** (reasons) 1. ***Services are not anticipated for this student*** 2. Student is not the correct age/grade to invite Agency Representative **(DORS, BHA, MDL only)** 3. Parent(s)/Student did not return the Consent form 4. Parent(s)/Student did not give consent for the Agency Representative to be invited to the meeting 5. Other: _____ (document reason)	**Yes:** Representative invited to the IEP Team meeting and listed on the meeting notice dated _____ (date) **No:** LSS did not invite the Agency Representative **N/A:** (reasons) 1. ***Services are not anticipated for this student*** 2. Student is not the correct age/grade to invite Agency Representative **(DORS, BHA, MDL only)** 3. Parent(s)/Student did not return the Consent form 4. Parent(s)/Student did not want the DORS Representative invited to the meeting **(DORS only)** 5. Parent(s)/Student did not give consent for the Agency Representative to be invited to the meeting 6. Other: _____ (document reason)

Addtional discussion:_____
_____
_____

Name: Agency: IEP Team Meeting Date: / /

COMMUNICATION (required)

Is the student's communication impacted by their disability? ◯ YES ◯ NO

(If yes, briefly describe how communication needs will be addressed in the IEP.) _____

_____

Does the student have a reliable means of symbolic communication (e.g., speech, sign language, augmentative communication)? ◯ YES ◯ NO

(If no, describe the goals, services or other supports that will be provided to develop effective communication.) _____

_____

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.

Decision(s):	Requires an **AT device(s)**	Requires an **AT service(s)**
◯ The student does not require AT device(s) or AT service(s).	No	No
◯ The student does not require AT device(s) but does require AT service(s).	No	Yes Additional data collection with trials is needed
◯ The student requires AT device(s) and requires AT service(s).	Yes	Yes Services may address the required device(s) or additional data collection with trials is needed
◯ The student requires AT device(s) but does not require AT service(s).	Yes	No

Document basis for decision(s) on AT device(s) including description of device(s): _____

_____

Document basis for decision(s) on AT service(s) including implementation of trials: _____

_____

SERVICE FOR STUDENTS WHO ARE BLIND OR VISUALLY IMPAIRED

Is the student blind or visually impaired? ◯ YES ◯ NO

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.

Braille Evaluation date: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY) Is instruction in Braille appropriate? ◯ YES ◯ NO

In the case of a student who is blind or visually impaired, provide for instruction in Orientation and Mobility (O&M) unless the IEP Team determines, after an assessment of the student's current and future travel needs, that instruction in O&M is not appropriate for the student.

O&M Evaluation date: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY) Is instruction in O&M appropriate? ◯ YES ◯ NO

Document basis for decision(s): _____

_____

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

Name: Agency: IEP Team Meeting Date: / /

SERVICE FOR STUDENTS WHO ARE DEAF OR HEARING IMPAIRED

Is the student deaf or hearing impaired? ◯ YES ◯ NO
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.

Document basis for decision(s):_____

_____

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

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: ☐☐•☐☐•☐☐☐☐

◯ Behavioral Intervention Plan (BIP) Date of Current BIP: ☐☐•☐☐•☐☐☐☐

Restraint

Is the IEP team considering the use of physical restraint as a part of the student's IEP and/or BIP? ◯ YES ◯ NO

Has the IEP team reviewed available data to identify any contraindications to the use of physical restraint based on the student's medical history or past trauma, including consultation with medical or mental health professionals as appropriate? _____

_____

Identify less intrusive, nonphysical interventions that will be used to respond to the student's behavior until physical restraint is used in an emergency situation. _____

_____

Is the school-based IEP team recommending the inclusion of physical restraint in the student's IEP and/or BIP? ◯ YES ◯ NO

Does the parent consent to the use of restraint as a part of the student's IEP and/or BIP?

◯ YES - Date of written consent: ☐☐•☐☐•☐☐☐☐ ◯ NO - Date of written refusal: ☐☐•☐☐•☐☐☐☐

◯ No response received within 15 business days of the IEP team meeting date

Seclusion – A public agency may not use seclusion as a behavioral health intervention for a student (2022 HB1255/SB0705).

Is the IEP team considering the use of seclusion as a part of the student's IEP and/or BIP? ◯ YES ◯ NO

Has the IEP team reviewed available data to identify any contraindications to the use of seclusion based on the student's medical history or past trauma, including consultation with medical or mental health professionals as appropriate? _____

_____

Identify less intrusive, nonphysical interventions that will be used to respond to the student's behavior until seclusion is used in an emergency situation. _____

_____

Is the school-based IEP team recommending the inclusion of seclusion in the student's IEP and/or BIP? ◯ YES ◯ NO

Does the parent consent to the use of seclusion as a part of the student's IEP and/or BIP?

◯ YES - Date of written consent: ☐☐•☐☐•☐☐☐☐ ◯ NO - Date of written refusal: ☐☐•☐☐•☐☐☐☐

◯ No response received within 15 business days of the IEP team meeting date

Name: Agency: IEP Team Meeting Date: / /

SERVICE FOR STUDENTS WHO ARE ENGLISH LEARNERS

In the case of a student who is an English Learner, 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 ASSESSMENT ACCESSIBILITY FEATURES

FEATURES FOR ALL STUDENTS (Available to ALL students, either through the online platform or externally provided)	**Instruction**	**MCAP**	**HSA Government**	**HSA MISA**	**MISA (Grades 5, 8)**	**Alt-MISA (DLM)**	**ELA and Mathematics DLM**	**ACCESS for ELLs**	**Kindergarten ACCESS for ELLs**	**Alt-ACCESS for ELLs**	**NAEP**
1b. Audio Amplification	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
1c. Bookmark (Flag Items for Review)	yes	yes	yes	yes	yes						
1e: Blank Scratch Paper	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
1f: Eliminate Answer Choice	yes	yes	yes	yes	yes						yes
1g: General Administration Directions Clarified	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
1h: General Administration Directions Read Aloud and Repeated as Needed	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
1i: Highlight Tool	yes	yes	yes	yes	yes	yes		yes	yes	yes	yes
1j: Headphones or Noise Buffers	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
1k: Line Reader Mask Tool	yes	yes	yes	yes	yes		yes	yes	yes	yes	yes
1l: Magnification/Enlargement Device	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
1m: NotePad	yes	yes	yes	yes	yes			yes			
1n: Pop-up Glossary	yes	yes	yes	yes	yes						
1o: Redirect Student	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
1p: Spell Check or External Spell Check Device	yes	yes	yes	yes	yes						
1t: Writing Tools [1]	yes	yes	yes	yes	yes	yes	yes				yes
1u: Graphic Organizer	yes										
1v: Audio materials	yes										yes

This reflects allowable features and accommodations in our current testing programs. Please check your Test Administrators' Manual for the most up to date information.

* Consult assessment specific guidelines for detailed information.
1t[1]: Not available for speaking portion

Document basis for decision:

_____

_____

Name: Agency: IEP Team Meeting Date: / /

INSTRUCTIONAL AND ASSESSMENT ACCESSIBILITY FEATURES

ACCESSIBILITY FEATURES FOR ALL STUDENTS (Must be identified in advance and documented in the student's Student Registration/Personal Needs Profile [SR/PNP]) Accessibility features MUST be used in instruction to provide adequate time and fairness for the student to be familiar with the tools/devices.	**Instruction**	**MCAP**	**HSA Government**	**HSA MISA**	**MISA (Grades 5, 8)**	**Alt-MISA (DLM)**	**ELA and Mathematics DLM**	**ACCESS for ELLs**	**Kindergarten ACCESS for ELLs**	**Alt-ACCESS for ELLs**	**NAEP**
1a: Answer Masking	yes	yes	yes	yes	yes	yes	yes				yes
1d: Color Contrast (Background/Font Color)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
1q: Student Reads Content Aloud to Him/Herself	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
1r: Text to Speech for the Mathematics, Science, and Government Assessments (A student's SR/PNP for mathematics may specify text only or text and graphics inclusion orders. Text only inclusion order provides selected sections.)	yes	yes*	yes*	yes*	yes*	yes	yes				yes
1s: Human Reader or Human Signer for the Mathematics, Science, and Government Assessments (entire text or selected sections)	yes	yes*	yes*	yes*	yes*	yes	yes				yes
2a: Small group	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
2b: Time of day	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
2c: Separate or alternate location	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
2d: Specified area or setting	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
2e: Adaptive or specialized equipment or furniture	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
2f: Frequent breaks	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
2g: Reduce distractions to self	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
2h: Reduce distractions to others	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
2i: Change location within school	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
2j: Change location outside school	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
2k: Unique accessibility feature	yes	*	*	*	*	*	*	*	*	*	*

This reflects allowable features and accommodations in our current testing programs. Please check your Test Administrators' Manual for the most up to date information.

* Consult assessment specific guidelines for detailed information.

Document basis for decision:

_____

_____

Name: Agency: IEP Team Meeting Date: / /

INSTRUCTIONAL AND ASSESSMENT ACCOMMODATIONS

PRESENTATION ACCOMMODATIONS FOR STUDENTS WITH DISABILITIES (Intended for students with disabilities who have the accommodation documented in an approved IEP or 504 Plan prior to the date of test administration; and who use the accommodation routinely (with rare exceptions) during instruction and locally administered assessments, both before and after the test is administered.)	**Instruction**	**MCAP**	**HSA Government**	**HSA MISA**	**MISA (Grades 5, 8)**	**Alt-MISA (DLM)**	**ELA and Mathematics DLM**	**ACCESS for ELLs**	**Kindergarten ACCESS for ELLs**	**Alt-ACCESS for ELLs**	**NAEP**
3a: Assistive Technology (Non-Screen Reader)	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
3b: Screen Reader Version (for a student who is blind or visually impaired).	yes	yes	yes	yes	yes						
3c: Refreshable Braille Display with Screen Reader Version for ELA/Literacy	yes	yes	yes	yes	yes						
3d: Hard Copy Braille Edition	yes	yes	yes	yes	yes	yes*		yes			yes
3e: Tactile Graphics	yes	yes	yes	yes	yes		yes				
3f: Large Print Edition	yes	yes	yes	yes	yes		yes	yes	yes*	yes*	yes
3g: Paper-based Edition	yes	yes	yes	yes	yes		yes*	yes	yes	yes	yes
3h: Closed-Captioning of Multimedia Passages	yes	yes	yes	yes	yes						yes
3i: Text to Speech for the ELA/Literacy Assessments, including items, response options, and passages. [1]	yes	yes					yes				
3j: ASL Video for the ELA/Literacy Assessments [1]	yes	yes									
3k: Human reader/Human Signer for ELA [1]	yes	yes					yes*				
3l: ASL Video for the Mathematics, Science, and Government Assessment	yes	yes	yes	yes	yes						
3m: Human Signer for Test Directions	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
3n: Human Reader, including manual control of item audio and repeat item audio (ACCESS only)	yes							yes			
3o: Notes and outlines	yes										
3p: Partner assisted scanning	yes	yes	yes	yes	yes	yes	yes				
3q: Unique presentation accommodations	yes	*	*	*	*	*	*	*	*	*	*

This reflects allowable features and accommodations in our current testing programs. Please check your Test Administrators' Manual for the most up to date information.

* Consult assessment specific guidelines for detailed information.
3i[1]; 3j[1]; 3k[1]: Appendix D must be completed.

Document basis for decision:

_____

_____

Name: Agency: IEP Team Meeting Date: / /

INSTRUCTIONAL AND ASSESSMENT ACCOMMODATIONS

RESPONSE ACCOMMODATIONS FOR STUDENTS WITH DISABILITIES (Intended for students with disabilities who have the accommodation documented in an approved IEP or 504 Plan prior to the date of test administration; and who use the accommodation routinely (with rare exceptions) during instruction and locally administered assessments, both before and after the test is administered.)	**Instruction**	**MCAP**	**HSA Government**	**HSA MISA**	**MISA (Grades 5, 8)**	**Alt-MISA (DLM)**	**ELA and Mathematics DLM**	**ACCESS for ELLs**	**Kindergarten ACCESS for ELLs**	**Alt-ACCESS for ELLs**	**NAEP**
4a: Assistive Technology	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes	yes
4b: Braille Note-Taker	yes	yes	yes	yes	yes			yes			yes*
4c: Braille Writer	yes	yes	yes	yes	yes	yes*	yes*	yes			yes*
4d: Calculation device and mathematics tools (on Calculation Sections of the Mathematics Assessments)	yes	yes		yes	yes		yes*				yes
4e: Calculation device and mathematics tools (on NON Calculation Sections of the Mathematics Assessments)	yes	yes		yes	yes	yes					
4f: ELA/Literacy Selected Response Speech-to-Text	yes	yes									
4g: ELA/Literacy Selected Response Human Scribe	yes	yes					yes				
4h: ELA/Literacy Selected Response Human Signer	yes	yes					yes				
4i: ELA/Literacy Selected Response Assistive Technology Device	yes	yes					yes				
4j: Mathematics, Science, Government Response Speech-to-Text	yes	yes	yes	yes	yes	yes	yes				yes
4k: Mathematics, Science, Government Response Human Scribe	yes	yes	yes	yes	yes	yes	yes				yes
4l: Mathematics, Science, Government Response Human Signer	yes	yes	yes	yes	yes	yes	yes				yes
4m: Mathematics, Science, Government Response Assistive Technology Device	yes	yes	yes	yes	yes	yes	yes				yes
4n: ELA/L Constructed Response Speech-to-Text	yes	yes					yes				yes
4o: ELA/L Response Human Scribe	yes	yes					yes				yes
4p: ELA/L Response Human Signer	yes	yes					yes				yes
4q: ELA/L Constructed Response External Assistive Technology Device	yes	yes					yes				yes
4r: Monitor Test Response	yes	yes	yes	yes	yes	yes	yes	yes*	yes*	yes*	yes
4s: Word Prediction External Device	yes	yes	yes	yes	yes						
4t: Answers Recorded in Test Book	yes	yes	yes					yes	yes	yes	
4u: Recording device [1]	yes							yes	yes	yes	
4v: ACCESS for ELLs Scribe	yes							yes	yes	yes	yes
4w: Unique response accommodations	yes	*	*	*	*	*	*	*	*	*	*

This reflects allowable features and accommodations in our current testing programs. Please check your Test Administrators' Manual for the most up to date information.

* Consult assessment specific guidelines for detailed information. 4u[1]: Available only for reading and writing on ACCESS For ELLs, Kindergarten ACCESS for ELLs, and Alt-ACCESS For ELLs

Document basis for decision:

_____

Name: Agency: IEP Team Meeting Date: / /

INSTRUCTIONAL AND ASSESSMENT ACCOMMODATIONS

TIMING ACCOMMODATIONS FOR STUDENTS WITH DISABILITIES (Intended for students with disabilities who have the accommodation documented in an approved IEP or 504 Plan prior to the date of test administration; and who use the accommodation routinely (with rare exceptions) during instruction and locally administered assessments, both before and after the test is administered.)	**Instruction**	**MCAP**	**HSA Government**	**HSA MISA**	**MISA (Grades 5, 8)**	**Alt-MISA (DLM)**	**ELA and Mathematics DLM**	**ACCESS for ELLs**	**Kindergarten ACCESS for ELLs**	**Alt-ACCESS for ELLs**	**NAEP**
5a: Extended Time ◯ 1.5x ◯ 2x ◯ Other: _____	yes	yes	yes	yes	yes			yes*			yes
5b: Unique timing and scheduling accommodations	yes	*	*	*	*	*	*	*	*	*	*

This reflects allowable features and accommodations in our current testing programs. Please check your Test Administrators' Manual for the most up to date information.

* Consult assessment specific guidelines for detailed information.

Document basis for decision:

_____

_____

IEP Planning for Emergency Conditions:

Can instructional and assessment accommodations be implemented as written during emergency conditions resulting in the physical closure of school for 10 or more days?

◯ YES ◯ NO If no, describe the changes needed to existing instructional and assessment accommodations: _____

_____

_____

◯ 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
◯ Allow use of highlighters during instruction and assignments ◯ Allow use of manipulatives ◯ Allow use of organizational aids ◯ Check for understanding ◯ Frequent and/or immediate feedback ◯ Have student repeat and/or paraphrase information ◯ Limit amount to be copied from board ◯ Monitor independent work ◯ Paraphrase questions & instruction ◯ Peer tutoring/paired work arrangement ◯ Picture schedule ◯ Provide alternative ways for students to demonstrate learning ◯ Provide assistance w/ organization ◯ Provide home sets of textbooks/materials ◯ Provide proofreading checklist ◯ Provide student w/ copy of student/teacher notes ◯ Repetition of directions ◯ Use of word bank to reinforce vocabulary and/or when extended writing is required ◯ Other: _____	Anticipated Frequency ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Periodically ◯ Quarterly ◯ Semi-annually ◯ Other _____	MM•DD•YYYY	MM•DD•YYYY Duration _____weeks	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Deaf and Hard of Hearing Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Teacher Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Teacher Ⓟ ◯ Career & Technology Teacher Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Behavioral Health Administration (BHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency_____ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider_____ Ⓟ ◯ Nurse Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ School Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ 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
◯ Altered/modified assignments ◯ Break down assignments into smaller units ◯ Chunking of text(s) ◯ Delete extraneous information on assignments and assessment, when possible ◯ Limit amount of required reading ◯ Modified content ◯ Modified grading system ◯ Open book exams ◯ Oral exams ◯ Reduce number of answer choices ◯ Reduced length of exams ◯ Remove "except" and "not" questions, when possible ◯ Revise format of test (i.e. fewer questions, fill-in-the-blank) ◯ Separate long paragraph questions into bullets, whenever possible ◯ Simplified sentence structure, vocabulary, and graphics on assignments and assessments ◯ Use pictures to support reading passages, whenever possible ◯ Other: _____	Anticipated Frequency ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Periodically ◯ Quarterly ◯ Semi-annually ◯ Other _____	MM•DD•YYYY	MM•DD•YYYY Duration _____weeks	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Deaf and Hard of Hearing Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Teacher Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Teacher Ⓟ ◯ Career & Technology Teacher Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Behavioral Health Administration (BHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency_____ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider_____ Ⓟ ◯ Nurse Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ School Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide

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

Clarify location and manner: _____
_____

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
◯ Access to elevator ◯ Adaptive equipment ◯ Adaptive feeding devices ◯ Adjustments to sensory input (i.e. light, sound) ◯ Allow extra time for movement between classes ◯ Environmental aids (i.e. classroom acoustics, heating, ventilation) ◯ Preferential locker location ◯ Preferential seating ◯ Reduce paper/pencil tasks ◯ Sensory diet ◯ Picture schedule ◯ Other: _____	Anticipated Frequency ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Periodically ◯ Quarterly ◯ Semi-annually ◯ Other _____	MM•DD•YYYY	MM•DD•YYYY Duration _____weeks	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Deaf and Hard of Hearing Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Teacher Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Teacher Ⓟ ◯ Career & Technology Teacher Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Behavioral Health Administration (BHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency_____ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider_____ Ⓟ ◯ Nurse Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ School Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide

Clarify location and manner: _____

_____

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
◯ AT consult ◯ Audiologist consult ◯ Classroom instruction consult ◯ Coordination of support services for crisis prevention and interventions ◯ Extracurricular/non academic providers support ◯ Occupational therapist consult ◯ Orientation and mobility consult ◯ Parent counseling and/or training ◯ Physical education consult ◯ Physical therapist consult ◯ Psychologist consult ◯ School health consult ◯ Social worker consult ◯ Speech/language pathologist consult ◯ Staff training ◯ Travel training ◯ Vision consult ◯ Other:	Anticipated Frequency ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Periodically ◯ Quarterly ◯ Semi-annually ◯ Other _____	MM•DD•YYYY	MM•DD•YYYY Duration _____weeks	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Deaf and Hard of Hearing Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Teacher Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Teacher Ⓟ ◯ Career & Technology Teacher Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Behavioral Health Administration (BHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency_____ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider_____ Ⓟ ◯ Nurse Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ School Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide

Identify area(s) of the IEP supported by the training/consultation:

☐ Goal(s) and objectives (evidence based interventions and strategies)
☐ Accommodations
☐ Supplementary Aids, Services, Program Modifications and Supports
☐ Special Education/Related Services

Clarify topic(s), participant(s), location, and manner: _____

_____

Documentation to Support Decision: _____

_____

IEP Planning for Emergency Conditions:

Can supplementary aids, services, program modifications, and supports be implemented as written during emergency conditions resulting in the physical closure of school for 10 or more days?

◯ YES ◯ NO If no, describe the changes needed to existing supplementary aids, services, program modifications and supports: _____

_____

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: / /

GOAL _____

Does this goal support a Postsecondary Transition Goal?
If so, identify: ☐ Employment ☐ Education ☐ Training ☐ Independent Living

Goal (include Conditions, Behavior, Timeframe, Method of Measurement, and Criteria): _____

_____

Timeframe: by ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

Method of Measurement (Select all that apply): ☐ INFORMAL PROCEDURES - (Tool/Method Used) _____ ☐ CLASSROOM-BASED ASSESSMENT - (Tool/Method Used) _____

☐ OBSERVATION RECORD ☐ STANDARDIZED ASSESSMENT - (Tool/Method Used) _____ ☐ PORTFOLIO ASSESSMENT ☐ OTHER _____

Criteria (Mastery and Retention): With _____ ☐ % Accuracy ☐ % decrease ☐ ____ out of ____ trials ☐ % increase ☐ other_____

ESY goal? ◯ YES ◯ NO

IEP Planning for Emergency Conditions: Can this goal be implemented as written during emergency conditions resulting in the physical closure of school for 10 or more days?
◯ YES ◯ NO If no, describe the changes needed to this goal: _____

Objective 1 (include Conditions, Behavior, Timeframe, Method of Measurement, and Criteria): _____

_____

Objective 2 (include Conditions, Behavior, Timeframe, Method of Measurement, and Criteria): _____

_____

Objective 3 (include Conditions, Behavior, Timeframe, Method of Measurement, and Criteria): _____

_____

Objective 4 (include Conditions, Behavior, Timeframe, Method of Measurement, and Criteria): _____

_____

Progress Toward Goal	
Progress Report 1 Date_____	Progress Code: ◯ Achieved ◯ Making sufficient progress to meet goal ◯ Newly introduced skill; progress not measurable at this time ◯ Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) ◯ Not yet introduced Description of Progress: _____
Progress Report 2 Date_____	Progress Code: ◯ Achieved ◯ Making sufficient progress to meet goal ◯ Newly introduced skill; progress not measurable at this time ◯ Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) ◯ Not yet introduced Description of Progress: _____
Progress Report 3 Date_____	Progress Code: ◯ Achieved ◯ Making sufficient progress to meet goal ◯ Newly introduced skill; progress not measurable at this time ◯ Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) ◯ Not yet introduced Description of Progress: _____
Progress Report 4 Date_____	Progress Code: ◯ Achieved ◯ Making sufficient progress to meet goal ◯ Newly introduced skill; progress not measurable at this time ◯ Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) ◯ Not yet introduced 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 _____

Name: Agency: IEP Team Meeting Date: / /

SERVICES

◯ SPECIAL EDUCATION SERVICES

Service Nature	Location	Service Description			Begin Date	End Date	Provider(s) Ⓟ = Primary, ◯ = Other	Summary of Service
◯ Classroom Instruction (Identifying the number of sessions for Classroom Instruction is optional) ◯ Physical Education ◯ Speech/Language Therapy ◯ Travel Training	◯ In General Education ◯ Outside General Education	Number of Sessions ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Other ____	Length of Time ____ Hours ____ Minutes	Frequency ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Quarterly ◯ Semi-annually	MM•DD YYYY	MM•DD YYYY Duration ____weeks	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Deaf and Hard of Hearing Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Teacher Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Teacher Ⓟ ◯ Career & Technology Teacher Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Behavioral Health Administration (BHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency____ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider____ Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ School Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide	Total service time: ◯ weekly ◯ monthly ◯ yearly ____Hrs. ____Min.

ESY Service Nature	ESY Location	ESY Service Description			ESY Begin Date	ESY End Date	ESY Provider(s) Ⓟ = Primary, ◯ = Other	Summary of Service
◯ Classroom Instruction (Identifying the number of sessions for Classroom Instruction is optional) ◯ Physical Education ◯ Speech/Language Therapy ◯ Travel Training	◯ In General Education ◯ Outside General Education	Number of Sessions ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Other ____	Length of Time ____ Hours ____ Minutes	Frequency ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Quarterly ◯ Semi-annually	MM•DD YYYY	MM•DD YYYY Duration ____weeks	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Deaf and Hard of Hearing Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Teacher Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Teacher Ⓟ ◯ Career & Technology Teacher Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Behavioral Health Administration (BHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency____ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider____ Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ School Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide	Total service time: ◯ weekly ◯ monthly ◯ yearly ____Hrs. ____Min.

Discussion of service(s) delivery:_____

_____

IEP Planning for Emergency Conditions: Can this service/ESY service be implemented as written during emergency conditions resulting in the physical closure of school for 10 or more days?

◯ YES ◯ NO If no, describe the changes needed to this service/ESY service: _____

_____

Name: Agency: IEP Team Meeting Date: / /

SERVICES

◯ RELATED SERVICES

Service Nature	Location	Service Description			Begin Date	End Date	Provider(s) Ⓟ = Primary, ◯ = Other	Summary of Service
◯ Audiological Services ◯ Psychological Services ◯ Occupational Therapy ◯ Physical Therapy ◯ Recreation ◯ Early Identification &Assessment ◯ Counseling Services ◯ School Health Services ◯ Social Work Services ◯ Parent Counseling & Training ◯ Rehabilitative Counseling ◯ Orientation & Mobility Training Services ◯ Medical Services (Diagnostic & Evaluation) ◯ Other Therapies _____ ◯ Interpreting Services ◯ Speech/Language Therapy ◯ Nursing Services	◯ In General Education ◯ Outside General Education	Number of Sessions ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Other ____	Length of Time ____ Hours ____ Minutes	Frequency ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Quarterly ◯ Semi-annually	MM•DD YYYY	MM•DD YYYY Duration _____weeks	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Deaf and Hard of Hearing Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Teacher Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Teacher Ⓟ ◯ Career & Technology Teacher Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Behavioral Health Administration (BHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency_____ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider_____ Ⓟ ◯ Nurse Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ School Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide	Total service time: ◯ weekly ◯ monthly ◯ yearly ____Hrs. ____Min.
◯ Transportation								

ESY Service Nature	ESY Location	ESY Service Description			ESY Begin Date	ESY End Date	ESY Provider(s) Ⓟ = Primary, ◯ = Other	Summary of Service
◯ Audiological Services ◯ Psychological Services ◯ Occupational Therapy ◯ Physical Therapy ◯ Recreation ◯ Early Identification &Assessment ◯ Counseling Services ◯ School Health Services ◯ Social Work Services ◯ Parent Counseling & Training ◯ Rehabilitative Counseling ◯ Orientation & Mobility Training Services ◯ Medical Services (Diagnostic & Evaluation) ◯ Other Therapies _____ ◯ Interpreting Services ◯ Speech/Language Therapy ◯ Nursing Services	◯ In General Education ◯ Outside General Education	Number of Sessions ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Other ____	Length of Time ____ Hours ____ Minutes	Frequency ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Quarterly ◯ Semi-annually Duration _____weeks	MM•DD YYYY	MM•DD YYYY Duration _____weeks	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Deaf and Hard of Hearing Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Teacher Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Teacher Ⓟ ◯ Career & Technology Teacher Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Behavioral Health Administration (BHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency_____ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider_____ Ⓟ ◯ Nurse Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ School Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide	Total service time: ◯ weekly ◯ monthly ◯ yearly ____Hrs. ____Min.
◯ Transportation								

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

IEP Planning for Emergency Conditions: Can this service/ESY service be implemented as written during emergency conditions resulting in the physical closure of school for 10 or more days?

◯ YES ◯ NO If no, describe the changes needed to this service/ESY service: _____

Name: Agency: IEP Team Meeting Date: / /

SERVICES

◯ CAREER AND TECHNOLOGY EDUCATION SERVICES

Service Nature	Location	Service Description			Begin Date	End Date	Provider(s) Ⓟ = Primary, ◯ = Other	Summary of Service
◯ Career and Technology Education Program w/ Support Services ◯ Vocational Evaluation ◯ Special Education Program with Pre-Vocation Objectives	◯ In General Education ◯ Outside General Education	Number of Sessions ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Other ____	Length of Time ____ Hours ____ Minutes	Frequency ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Quarterly ◯ Semi-annually	MM•DD YYYY	MM•DD YYYY Duration ____weeks	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Deaf and Hard of Hearing Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Teacher Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Teacher Ⓟ ◯ Career & Technology Teacher Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Behavioral Health Administration (BHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency____ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider____ Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ School Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide	Total service time: ◯ weekly ◯ monthly ◯ yearly ____Hrs. ____Min.

ESY Service Nature	ESY Location	ESY Service Description			ESY Begin Date	ESY End Date	ESY Provider(s) Ⓟ = Primary, ◯ = Other	Summary of Service
◯ Career and Technology Education Program w/ Support Services ◯ Vocational Evaluation ◯ Special Education Program with Pre-Vocation Objectives	◯ In General Education ◯ Outside General Education	Number of Sessions ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Other ____	Length of Time ____ Hours ____ Minutes	Frequency ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Only once ◯ Quarterly ◯ Semi-annually	MM•DD YYYY	MM•DD YYYY Duration ____weeks	Ⓟ ◯ Orientation & Mobility Specialist Ⓟ ◯ Speech/Language Pathologist Ⓟ ◯ Teacher of the Deaf and Hard of Hearing Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Teacher Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Teacher Ⓟ ◯ Career & Technology Teacher Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Behavioral Health Administration (BHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency____ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider____ Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ School Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide	Total service time: ◯ weekly ◯ monthly ◯ yearly ____Hrs. ____Min.

Discussion of service(s) delivery: _____

IEP Planning for Emergency Conditions: Can this service/ESY service be implemented as written during emergency conditions resulting in the physical closure of school for 10 or more days?

◯ YES ◯ NO If no, describe the changes needed to this service/ESY service: _____

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.
Each public agency must ensure that :
(i) To the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are nondisabled; and
(ii) Special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.
34 CFR § 300.114

List ALL placement options considered by the IEP Team. _____

Indicate the placement option selected. _____

Indicate the Least Restrictive Environment selected.

◯ Special education placement (Preschool Age 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 (School Age K-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

Document the basis for the LRE determination, and 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. _____

Indicate specific times/activities the student will not participate with nondisabled peers in academic, non-academic, and extracurricular activities or click NA if included 100% of the day.

☐ NA (included 100% of the day) _____

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, explain:_____

Are the services ***in*** the student's home school (the school the student would attend if not disabled)? ◯ YES ◯ NO

Consideration of Transportation Needs:
The public agency shall ensure that the educational placement decision of a student with a disability is as close as possible to the student's home. COMAR 13a.05.01.10C(1)(a)(v)

Does the student require special transportation? ◯ YES ◯ NO If yes explain and consider the amount of time and distance involved in travel:_____

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

SSIS Residence County_____
SSIS Residence School _____
SSIS Service County _____
SSIS Service School _____

Name: Agency: IEP Team Meeting Date: / /

LEAST RESTRICTIVE ENVIRONMENT (LRE) DECISION MAKING & PLACEMENT SUMMARY

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Each public agency must ensure that :
(i) To the maximum extent appropriate, children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are nondisabled; and
(ii) Special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.
34 CFR § 300.114

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.

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 (MDH), 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:**

_____ _____