

# INDIVIDUALIZED EDUCATION PROGRAM (IEP)

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

- Draft  
 Approved  
 Amended \_\_\_\_\_

## Student Information

Name: \_\_\_\_\_ Agency: \_\_\_\_\_ IEP Team Meeting Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### STUDENT AND SCHOOL INFORMATION

First Name: \_\_\_\_\_ MI: \_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Grade: \_\_\_\_\_

Unique Student Identification Number (State): \_\_\_\_\_

Student Identification Number (local): \_\_\_\_\_

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

Age: \_\_\_\_\_ Gender:  MALE  FEMALE

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

Student identified as Limited English Proficient:  YES  NO

Student's native language: \_\_\_\_\_

Residence County: \_\_\_\_\_

Residence School: \_\_\_\_\_

Service County: \_\_\_\_\_

Service School: \_\_\_\_\_

Which jurisdiction is financially responsible? \_\_\_\_\_

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

If yes, name of state agency: \_\_\_\_\_

Does the student require a parent surrogate?  YES  NO

Parent Surrogate Name: \_\_\_\_\_ Surrogate Phone: \_\_\_\_\_

### PARENT/GUARDIAN 1

First Name: \_\_\_\_\_ MI: \_\_\_\_ Last Name: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Parent native language, if not English: \_\_\_\_\_

Interpreter needed?  YES  NO

### PARENT/GUARDIAN 2

First Name: \_\_\_\_\_ MI: \_\_\_\_ Last Name: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Parent native language, if not English: \_\_\_\_\_

Interpreter needed?  YES  NO

Case Manager: \_\_\_\_\_

IEP Team Meeting Date(s): \_\_\_\_\_

IEP Annual Review Date: \_\_\_\_\_

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

Projected Annual Review Date: \_\_\_\_\_

Most Recent Evaluation Date: \_\_\_\_\_

Projected Evaluation Date: \_\_\_\_\_

Primary Disability: \_\_\_\_\_

Areas affected by disability: \_\_\_\_\_

### EXIT INFORMATION

Exit date:   •   •     (MM•DD•YYYY)

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

### IEP TEAM PARTICIPANTS

IEP Case Manager: \_\_\_\_\_ 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 is not eligible for special education.)

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

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

Indicate primary disability

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

Date of parent consent for initial evaluation: 


 (MM•DD•YYYY)

Date of initial evaluation: 


 (MM•DD•YYYY)

Date of initial IEP development: 


 (MM•DD•YYYY)

Date of parent consent for initiation of services: 


 (MM•DD•YYYY)

Date of implementation of initial IEP: 


 (MM•DD•YYYY)

Reason(s) for delay:  Student not available  Parent requested delay  Other, explain \_\_\_\_\_

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

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

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

Specify the area(s) identified for reevaluation: \_\_\_\_\_

Discussion to support decision: \_\_\_\_\_

Evaluation Date: 


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

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

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

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

Indicate primary disability

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

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## I. MEETING AND IDENTIFYING INFORMATION

Name: \_\_\_\_\_ Agency: \_\_\_\_\_ IEP Team Meeting Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### STUDENT PARTICIPATION ON DISTRICT/STATEWIDE ASSESSMENTS AND GRADUATION INFORMATION

Graduation requirements explained to parents?  YES  NO

Will the student participate in the Maryland School Assessment aligned with grade level academic achievement standards in assessed grade? (MSA)

Reading  YES  NO      Math  YES  NO      Science  YES  NO

Will the student participate in the Modified Maryland School Assessment aligned with modified academic achievement standards in assessed grade? (Mod-MSA)

Reading  YES  NO      Math  YES  NO      Science  YES  NO

Will the student participate in the Maryland High School Assessment aligned with course content standards in assessed grade? (HSA)

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

Will the student participate in the Maryland High School Assessment aligned with modified course content standards in assessed grade? (Mod-HSA)

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

Is the student to participate in Alternate Maryland School Assessment aligned with alternate academic achievement standards in reading, math and science? (Alt-MSA)

YES  NO

Document basis for decision(s): \_\_\_\_\_

Student is pursuing a:

Maryland High School Diploma     Maryland High School Certificate of Program Completion

State graduation requirements can be found at [www.marylandpublicschools.org](http://www.marylandpublicschools.org).

Also record any additional local school system graduation requirements:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

□□.□□.□□□□ (MM•DD•YYYY)

FULL     APPROACHING     DEVELOPING

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

Assessment Date □□.□□.□□□□ (MM•DD•YYYY)

Score \_\_\_\_\_

FULLY PROFICIENT     LIMITED PROFICIENCY     NOT PROFICIENT

Is the student limited English proficient?  YES  NO

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

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

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

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

HSA Assessments (Check Mod, if appropriate.)    Passing Score    Minimum Score    Student's Score    Meets Standard

HSA Assessments (Check Mod, if appropriate.)	Passing Score	Minimum Score	Student's Score	Meets Standard
English <input type="checkbox"/> Mod	396	386		<input type="radio"/> YES <input type="radio"/> NO
Algebra/ Data Analysis <input type="checkbox"/> Mod	412	402		<input type="radio"/> YES <input type="radio"/> NO
Government	394	387		<input type="radio"/> YES <input type="radio"/> NO
Biology <input type="checkbox"/> Mod	400	391		<input type="radio"/> YES <input type="radio"/> NO
Composite Score				<input type="radio"/> YES <input type="radio"/> NO

What was the student's performance on Alt-MSA? □□.□□.□□□□ (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

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

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

IEP Team Meeting Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## 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): \_\_\_\_\_

Instructional Grade Level Performance: \_\_\_\_\_

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

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

## HEALTH \_\_\_\_\_

Source(s): \_\_\_\_\_ Summary of Assessment Findings (including dates of administration): \_\_\_\_\_

Level of Performance: \_\_\_\_\_

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

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

## PHYSICAL \_\_\_\_\_

Source(s): \_\_\_\_\_ Summary of Assessment Findings (including dates of administration): \_\_\_\_\_

Level of Performance: \_\_\_\_\_

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

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

## BEHAVIORAL \_\_\_\_\_

Source(s): \_\_\_\_\_ Summary of Assessment Findings (including dates of administration): \_\_\_\_\_

Level of Performance: \_\_\_\_\_

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

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

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

Name:

Agency:

IEP Team Meeting Date: / /

## PRESENT LEVEL OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

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

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

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

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

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# INDIVIDUALIZED EDUCATION PROGRAM (IEP)

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# III. SPECIAL CONSIDERATIONS AND ACCOMMODATIONS

Name:

Agency:

IEP Team Meeting Date: / /

## COMMUNICATION (required)

Does the student have special communication needs?  YES  NO

(If yes, describe the specific needs.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## ASSISTIVE TECHNOLOGY (AT) (required)

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

Was assistive technology considered?  YES  NO

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

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

If yes, list AT device(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Document basis for decision(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## SERVICE FOR STUDENTS WHO ARE BLIND OR VISUALLY IMPAIRED

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

Instruction in Braille considered?  YES  NO

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

Is instruction in Braille appropriate?  YES  NO

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

Document basis for decision(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## SERVICE FOR STUDENTS WHO ARE DEAF OR HEARING IMPAIRED

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

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

Document basis for decision(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name:

Agency:

IEP Team Meeting Date: / /

### BEHAVIORAL INTERVENTION

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

Functional Behavioral Assessment (FBA) Assessment date:   •   •

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

Behavioral Intervention Plan Implementation date:   •   •

Document basis for decision(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### SERVICE FOR STUDENTS WITH LIMITED ENGLISH PROFICIENCY

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

Document basis for decision(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_ Agency: \_\_\_\_\_ IEP Team Meeting Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## INSTRUCTIONAL AND TESTING ACCOMMODATIONS

### PRESENTATION ACCOMMODATIONS:

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

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

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

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

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

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

✓ Check indicates applicable accommodation(s).

Discussion to support decision: \_\_\_\_\_ Page 8

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

IEP Team Meeting Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### INSTRUCTIONAL AND TESTING ACCOMMODATIONS

#### RESPONSE ACCOMMODATIONS:

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

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

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

✓ Check indicates applicable accommodation(s).

Discussion to support decision: \_\_\_\_\_

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

IEP Team Meeting Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### INSTRUCTIONAL AND TESTING ACCOMMODATIONS

#### TIMING AND SCHEDULING ACCOMMODATIONS:

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

✓ Check indicates applicable accommodation(s).

Discussion to support decision: \_\_\_\_\_  
 \_\_\_\_\_

#### SETTING ACCOMMODATIONS:

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

✓ Check indicates applicable accommodation(s).

Discussion to support decision: \_\_\_\_\_  
 \_\_\_\_\_

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

Discussion to support decision: \_\_\_\_\_

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

IEP Team Meeting Date: / /

### SUPPLEMENTARY AIDS, SERVICES, PROGRAM MODIFICATIONS AND SUPPORTS

Service Nature	Service Description	Begin Date	End Date	Provider(s) ○ = Primary, ○ = Other
○ _____	Anticipated Frequency <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"/> Other _____	MM•DD•YYYY	MM•DD•YYYY	<input type="checkbox"/> Orientation & Mobility Specialist <input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Teacher of the Hearing Impaired <input type="checkbox"/> Teacher of the Visually Impaired <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Pupil Personnel Worker <input type="checkbox"/> Physical Education Tchr <input type="checkbox"/> Rehabilitation Services Staff <input type="checkbox"/> General Education Tchr <input type="checkbox"/> Career & Technology Tchr <input type="checkbox"/> Department of Social Services (DSS) <input type="checkbox"/> Mental Hygiene Administration (MHA) <input type="checkbox"/> Developmental Disabilities Administration (DDA) <input type="checkbox"/> Division of Rehabilitation Services (DORS) <input type="checkbox"/> Other Agency _____ <input type="checkbox"/> Special Education Classroom Teacher <input type="checkbox"/> Other Service Provider _____

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

Discussion to support decisions: \_\_\_\_\_

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

Discussion to support decision(s): \_\_\_\_\_

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

IEP Team Meeting Date: / /

### EXTENDED SCHOOL YEAR (ESY)

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

ESY Decision Deferred

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

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

Discussion to support decision: \_\_\_\_\_

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

Discussion to support decision: \_\_\_\_\_

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

Discussion to support decision: \_\_\_\_\_

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

Discussion to support decision: \_\_\_\_\_

3. Are there significant interfering behaviors?  YES  NO

Discussion to support decision: \_\_\_\_\_

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

Discussion to support decision: \_\_\_\_\_

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

Discussion to support decision: \_\_\_\_\_

After considering all of the above questions, will the benefits that the student receives from his/her educational program during the regular school year be significantly jeopardized if the student is not provided ESY?  YES, student will receive ESY service.

NO, student will not receive ESY service.

Document basis for decision(s): \_\_\_\_\_

Name: \_\_\_\_\_ Agency: \_\_\_\_\_ IEP Team Meeting Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

#### STUDENT PREFERENCES AND INTERESTS:

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

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

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

#### POSTSECONDARY GOALS:

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

Training: \_\_\_\_\_

Education: \_\_\_\_\_

Employment (required): \_\_\_\_\_

Independent Living (if appropriate): \_\_\_\_\_

#### COURSE OF STUDY:

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

- |   |  |  |
|---|--|--|
| <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 DATE OF EXIT:

The student is projected to exit/graduate school \_\_\_\_\_ (month, day, year)

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

#### PROJECTED CATEGORY OF EXIT:

- The student will exit with:  Maryland High School Diploma
- with 2 credits of Foreign Language
  - with 2 credits of Advanced Technology
  - with 4 credits of Career and Technology Program
- Certificate of Program Completion at age 21
- Certificate of Program Completion prior to age 21

#### AGENCY LINKAGE:

The student has been referred to the appropriate agency for transition and/or postsecondary services:

- DORS (Department of Rehabilitative Services)
- DDA (Developmental Disabilities Agency)
- MHA (Mental Hygiene Administration)

Document basis for decision(s): \_\_\_\_\_

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

IEP Team Meeting Date: / /

### TRANSITION ACTIVITIES

#### TRANSITION SERVICES/ACTIVITIES:

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

Academic: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Employment Training: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Activities of Daily Living: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Independent Living: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Transportation: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Name:

Agency:

IEP Team Meeting Date: / /

### ANTICIPATED SERVICES FOR TRANSITION

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

#### General Services

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

#### 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)

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

## IV. GOALS

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"/> <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"/> OTHER _____	

# INDIVIDUALIZED EDUCATION PROGRAM (IEP)

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

## V. SERVICES

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"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Recheck Periodically	MM•DD YYYY	MM•DD YYYY	<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	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"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Recheck Periodically	MM•DD YYYY	MM•DD YYYY	<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	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)

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

## V. SERVICES

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"/> 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"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Recheck Periodically	MM•DD YYYY	MM•DD YYYY	<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	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"/> 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"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Recheck Periodically	MM•DD YYYY	MM•DD YYYY	<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	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)

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

## V. SERVICES

Name: \_\_\_\_\_

Agency: \_\_\_\_\_

IEP Team Meeting Date: / /

### SERVICES

CAREER AND TECHNOLOGY EDUCATION SERVICES

Service Nature	Location	Service Description			Begin Date	End Date	Provider(s) <input type="radio"/> = Primary, <input type="radio"/> = Other		Summary of Service
<input type="radio"/> Career and Technology Education Program w/Support Services <input type="radio"/> Special Career and Technology Education Program for Disabled <input type="radio"/> Vocational Evaluation <input type="radio"/> Special Education Program with Pre-Vocational 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"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Recheck Periodically	MM•DD YYYY	MM•DD YYYY	<input type="checkbox"/> Orientation & Mobility Specialist <input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Teacher of the Hearing Impaired <input type="checkbox"/> Teacher of the Visually Impaired <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Pupil Personnel Worker <input type="checkbox"/> Physical Education Tchr <input type="checkbox"/> Rehabilitation Services Staff <input type="checkbox"/> General Education Tchr <input type="checkbox"/> Career & Technology Tchr <input type="checkbox"/> Department of Social Services (DSS) <input type="checkbox"/> Mental Hygiene Administration (MHA) <input type="checkbox"/> Developmental Disabilities Administration (DDA) <input type="checkbox"/> Division of Rehabilitation Services (DORS) <input type="checkbox"/> Other Agency _____ <input type="checkbox"/> Special Education Classroom Teacher <input type="checkbox"/> Other Service Provider _____	<input type="checkbox"/> Audiologist <input type="checkbox"/> Psychologist <input type="checkbox"/> IEP Team <input type="checkbox"/> Interpreter <input type="checkbox"/> Instructional Assistant <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Home-Based Teacher <input type="checkbox"/> Guidance Counselor <input type="checkbox"/> School Social Worker <input type="checkbox"/> Recreational Therapist	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) <input type="radio"/> = Primary, <input type="radio"/> = Other		Summary of Service
<input type="radio"/> Career and Technology Education Program w/Support Services <input type="radio"/> Special Career and Technology Education Program for Disabled <input type="radio"/> Vocational Evaluation <input type="radio"/> Special Education Program with Pre-Vocational 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"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Recheck Periodically	MM•DD YYYY	MM•DD YYYY	<input type="checkbox"/> Orientation & Mobility Specialist <input type="checkbox"/> Speech/Language Pathologist <input type="checkbox"/> Teacher of the Hearing Impaired <input type="checkbox"/> Teacher of the Visually Impaired <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Pupil Personnel Worker <input type="checkbox"/> Physical Education Tchr <input type="checkbox"/> Rehabilitation Services Staff <input type="checkbox"/> General Education Tchr <input type="checkbox"/> Career & Technology Tchr <input type="checkbox"/> Department of Social Services (DSS) <input type="checkbox"/> Mental Hygiene Administration (MHA) <input type="checkbox"/> Developmental Disabilities Administration (DDA) <input type="checkbox"/> Division of Rehabilitation Services (DORS) <input type="checkbox"/> Other Agency _____ <input type="checkbox"/> Special Education Classroom Teacher <input type="checkbox"/> Other Service Provider _____	<input type="checkbox"/> Audiologist <input type="checkbox"/> Psychologist <input type="checkbox"/> IEP Team <input type="checkbox"/> Interpreter <input type="checkbox"/> Instructional Assistant <input type="checkbox"/> Physical Therapist <input type="checkbox"/> Home-Based Teacher <input type="checkbox"/> Guidance Counselor <input type="checkbox"/> School Social Worker <input type="checkbox"/> Recreational Therapist	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)

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

## VI. PLACEMENT DATA

Name: \_\_\_\_\_ Agency: \_\_\_\_\_ IEP Team Meeting Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### LEAST RESTRICTIVE ENVIRONMENT (LRE) DECISION MAKING & PLACEMENT SUMMARY

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

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

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

Document basis for decision(s): \_\_\_\_\_

{ Total time in school week: \_\_\_\_hrs. \_\_\_\_minutes/week } - { Total time outside of General Education: \_\_\_\_hrs. \_\_\_\_minutes/week } = { Total time in General Education: \_\_\_\_hrs. \_\_\_\_minutes/week }

- Special education placement (ages 3-5): Average \_\_\_\_%/day
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> IN REGULAR EARLY CHILDHOOD SETTING (at least 80%)  | <input type="checkbox"/> PUBLIC SEPARATE DAY SCHOOL   | <input type="checkbox"/> HOME                      |
| <input type="checkbox"/> IN REGULAR EARLY CHILDHOOD SETTING (40% - 79%)     | <input type="checkbox"/> PRIVATE SEPARATE DAY SCHOOL  | <input type="checkbox"/> SERVICE PROVIDER LOCATION |
| <input type="checkbox"/> IN REGULAR EARLY CHILDHOOD SETTING (less than 40%) | <input type="checkbox"/> PUBLIC RESIDENTIAL FACILITY  |  |
| <input type="checkbox"/> SEPARATE CLASS                                     | <input type="checkbox"/> PRIVATE RESIDENTIAL FACILITY |  |
- Special education placement (ages 6-21): Average \_\_\_\_%/day
- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> INSIDE GENERAL EDUCATION (80% or more)   | <input type="checkbox"/> PUBLIC SEPARATE DAY SCHOOL  | <input type="checkbox"/> PRIVATE RESIDENTIAL FACILITY | <input type="checkbox"/> PARENTALLY PLACED IN PRIVATE SCHOOL |
| <input type="checkbox"/> INSIDE GENERAL EDUCATION (40% - 79%)     | <input type="checkbox"/> PRIVATE SEPARATE DAY SCHOOL | <input type="checkbox"/> HOMEBOUND/HOSPITAL           |  |
| <input type="checkbox"/> INSIDE GENERAL EDUCATION (less than 40%) | <input type="checkbox"/> PUBLIC RESIDENTIAL FACILITY | <input type="checkbox"/> CORRECTIONAL FACILITIES      |  |

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

If yes, document basis for decision(s): \_\_\_\_\_

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

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

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.

# INDIVIDUALIZED EDUCATION PROGRAM (IEP)

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

## VII. AUTHORIZATION(S)

Name:

Agency:

IEP Team Meeting Date: / /

### AUTHORIZATION(S)

#### CONSENT FOR INITIATION OF SERVICES (initial IEP only)

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

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

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

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

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

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

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

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

Parent Signature:

Date:

\_\_\_\_\_

\_\_\_\_\_

### MEDICAL ASSISTANCE (MA)

Is the student eligible for MA?  Yes  No MA Number \_\_\_\_\_

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

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

MA Service Coordinator Name: \_\_\_\_\_

MA Service Coordinator Name: \_\_\_\_\_

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

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

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

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

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

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

Parent Signature:

Date:

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