INDIVIDUALIZED EDUCATION PROGRAM (IEP)

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2014)

Student Information ◯ Draft ______ ◯ Approved ◯ Amended ______

Name: Agency: IEP Team Meeting Date: / /

STUDENT AND SCHOOL INFORMATION

First Name: ______ Middle Name: ______ Last Name: ______
Address: ______
City: ______ State: ______ Zip Code: ______
Grade: ______
Unique Student Identification Number (State): ______
Student Identification Number (local): ______
Date of Birth: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)
Age: ______ Gender: ◯ MALE ◯ FEMALE

RACE CODES

Ethnicity: Hispanic or Latino ☐ Yes ☐ No
☐ American Indian or Alaskan Native
☐ Asian
☐ White
☐ Native Hawaiian or other Pacific Islander
☐ Black or African American

Student identified as Limited English Proficient: ◯ YES ◯ NO
Student's native language: ______
Residence County: ______
Residence School: ______
Service County: ______
Service School: ______
Which jurisdiction is financially responsible? ______
Is the student currently under the care and custody of a state agency? ◯ YES ◯ NO
If yes, name of state agency: ______
Does the student require a parent surrogate? ◯ YES ◯ NO
Parent Surrogate Name: ______ Surrogate Phone: ______

PARENT/GUARDIAN 1
First Name: ______ MI: ____ Last Name: ______
Home Phone: (____) ____-______ Cell: (____) ____-______
Email: ______
Parent native language, if not English: ______
Interpreter needed? ◯ YES ◯ NO

PARENT/GUARDIAN 2
First Name: ______ MI: ____ Last Name: ______
Home Phone: (____) ____-______ Cell: (____) ____-______
Email: ______
Parent native language, if not English: ______
Interpreter needed? ◯ YES ◯ NO

Case Manager: ______
IEP Team Meeting Date(s): ______
IEP Annual Review Date: ______

◯ Parent was provided a copy of the *Procedural Safeguards Parental Rights* document.
◯ The parents were provided a verbal and written explanation of the parents' rights and responsibilities in the IEP team process.
◯ Parents were provided verbal and written information about access to habilitative services, including a copy of the Maryland Insurance Administration's Parents' Guide to Habilitative Services.

Projected Annual Review Date: ______
Most Recent Evaluation Date: ______
Projected Evaluation Date: ______
Primary Disability: ______

EXIT INFORMATION

Exit date: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

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

IEP TEAM PARTICIPANTS

IEP Case Manager: ______
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: ______

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

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

Discussion to support decision: ______________________________

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

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

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

c) limited English proficiency? ○ YES ○ NO

(If yes to any of the above, the student must otherwise meet the eligibility criteria as a student with an identified disability.)

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

Initial Eligibility (Prior to Age 3)

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

Indicate primary disability

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

Document basis for decision(s): ______________________________

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

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

Reason(s) for delay of initial evaluation:

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

○ Initial evaluation

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

○ Parent repeatedly failed or refused to make the child available
○ Parent refusal to provide consent caused delay in evaluation or initial services
○ Parent requested delay - Parent and IEP team extend the timeframe by mutual written agreement
○ School/facility closure
○ Inclement weather
○ Other
  ○ Staffing issues ○ Paperwork error
  ○ Inconclusive testing results
  ○ Other, please specify: ____________

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

Date of initial IEP development: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

Date of parent consent for initiation of services: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

Date initial IEP is in effect: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

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

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

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

○ Initial IEP in effect by age 3

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

○ Parent repeatedly failed or refused to make the child available
○ Parent refusal to provide consent caused delay in evaluation or initial services
○ Parent requested delay - Parent and IEP team extend the timeframe by mutual written agreement
○ School/facility closure
○ Inclement weather
○ Other
  ○ Staffing issues ○ Paperwork error
  ○ Inconclusive testing results
  ○ Other, please specify: ____________

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

Initial Eligibility (Student Ages 3-21)

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

Indicate primary disability

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

◯ Cognitive (specify) ________________
◯ Sensory (specify ________________
◯ Physical (specify) ________________

Document basis for decision(s): ________________________________

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

Reason(s) for delay of initial evaluation

◯ Eligibility not determined due to withdrawal, 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 ◯ VISUAL IMPAIRMENT
◯ DEAF ◯ EMOTIONAL DISABILITY ◯ ORTHOPEDIC IMPAIRMENT ◯ SPEECH OR LANGUAGE IMPAIRMENT ◯ MULTIPLE DISABILITIES
◯ DEAF - BLINDNESS ◯ HEARING IMPAIRMENT ◯ OTHER HEALTH IMPAIRMENT ◯ TRAUMATIC BRAIN INJURY

◯ Cognitive (specify) ________________
◯ Sensory (specify) ________________
◯ Physical (specify) ________________

STUDENT PARTICIPATION ON DISTRICT/STATEWIDE ASSESSMENTS AND GRADUATION INFORMATION

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

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

Also record any additional local school system graduation requirements:

___

Graduation requirements explained to parents? ◯ YES ◯ NO

Will the student participate in an alternate assessment based on alternate academic achievement standards in assessed grade in
•reading •math •science? ◯ YES ◯ NO

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

Will the student participate in the Maryland School Assessment aligned with grade level academic achievement standards in assessed grade? (Grades 5 and 8)
Science ◯ YES ◯ NO

Will the student participate in the Maryland High School Assessment in assessed course?
Algebra/Data Analysis ◯ YES ◯ NO Biology ◯ YES ◯ NO English ◯ YES ◯ NO Government ◯ YES ◯ NO

Will the student participate in the Maryland High School Assessment aligned with Modified Achievement Standards in assessed course?
Algebra/Data Analysis ◯ YES ◯ NO Biology ◯ YES ◯ NO English ◯ YES ◯ NO Government ◯ YES ◯ NO

Will the student participate in the PARCC Assessments for grades 3 through 8?
English Language Arts/Literacy ◯ YES ◯ NO Mathematics ◯ YES ◯ NO

Will the student participate in the PARCC Assessments for high school?
English Language Arts/literacy ◯ YES ◯NO Algebra I ◯ YES ◯ NO Geometry ◯ YES ◯ NO Algebra II ◯ YES ◯ NO

Document basis for assessment decision(s):___

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

Complete for high school seniors that may be eligible for an HSA waiver
IEP team has discussed the criteria of the waiver decision-making process for the student and supports an HSA waiver recommendation to the local superintendent.

◯ YES **(If yes, specify date recommended) ___** ◯ NO

PERFORMANCE SUMMARY

Is the student limited English proficient? ◯ YES ◯ NO

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

Assessment Date ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY) Overall Composite Proficiency Level ___________

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

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

Assessment Date ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY) Overall Composite Proficiency Level ____________

◯ INITIATING ◯ EXPLORING ◯ ENGAGING ◯ ENTERING ◯ EMERGING

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

MSA Assessments	Most Current Proficiency Levels			Current Scale Score	Last Year's Scale Score
Reading	◯ BASIC	◯ PROFICIENT	◯ ADVANCED		
Math	◯ BASIC	◯ PROFICIENT	◯ ADVANCED		
Science	◯ BASIC	◯ PROFICIENT	◯ ADVANCED		

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

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

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

☐☐•☐☐•☐☐☐☐ ?

Alternate Assessments	% of Mastery Objectives	Most Current Proficiency Levels		
Reading		◯ BASIC	◯ PROFICIENT	◯ ADVANCED
Math		◯ BASIC	◯ PROFICIENT	◯ ADVANCED
Science		◯ BASIC	◯ PROFICIENT	◯ ADVANCED

What was the student's performance on PARCC Assessments?

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

Name: Agency: IEP Team Meeting Date: / /

ACADEMIC ______________________________

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

Source(s): ____

Instructional Grade Level Performance: ______________________________

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

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

____

____

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

HEALTH ______________________________

Source(s): ____

Level of Performance: ____

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

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

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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): ______________

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

BEHAVIORAL ______________________________

Source(s): ____

Level of Performance: ____

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

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

____

____

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

Name: Agency: IEP Team Meeting Date: / /

PRESENT LEVEL OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

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

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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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____

Name: Agency: IEP Team Meeting Date: / /

COMMUNICATION (required)

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

(If yes, describe the specific needs.) ____________________

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ASSISTIVE TECHNOLOGY (AT) (required)

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

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

If yes, AT ***device(s)*** will be addressed through:
◯ Supplementary Aids, Services,Program Modifications, and Supports
◯ Instructional and Testing Accommodations

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

If yes, AT ***service(s)*** will be addressed through:
◯ Supplementary Aids, Services, Program Modifications, and Supports
◯ Related Services
◯ Instructional and Testing Accommodations

Document basis for decision(s): ____________________

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SERVICE FOR STUDENTS WHO ARE BLIND OR VISUALLY IMPAIRED

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

Instruction in Braille considered? ◯ YES ◯ NO

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

Is instruction in Braille appropriate? ◯ YES ◯ NO

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

Document basis for decision(s): ____________________

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SERVICE FOR STUDENTS WHO ARE DEAF OR HEARING IMPAIRED

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

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

Document basis for decision(s): ____________________

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BEHAVIORAL INTERVENTION

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

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

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

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

Document basis for decision(s): ______________________________

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SERVICE FOR STUDENTS WITH LIMITED ENGLISH PROFICIENCY

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

Document basis for decision(s): ______________________________

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____

Name: Agency: IEP Team Meeting Date: / /

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

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

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

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

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

[2] Use of the verbatim reading accommodation is permitted on all assessments as a standard accommodation, with the exception of the Maryland School Assessment (MSA) in reading, grade 3 ONLY, which assesses a student's ability to decode printed language. Students in grade 3 receiving this accommodation on the assessment will receive a score based on standards 2 and 3 (comprehension of informational and literary reading material) but will not receive a subscore for standard 1, general reading processes.

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

Document basis for decision:

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____

Name: Agency: IEP Team Meeting Date: / /

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

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

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

Response Accommodations	Conditions for Use In Instruction and Assessment
2-A: Scribe	I, A
2-B: Augmentative Communication System and Speech Generating Devices*	I, A
2-C: Braillewriter	I, A
2-D: Electronic Word Processors	I, A
2-E: Electronic Braille Notetakers	I, A
2-F: Recording Devices	I, A
Materials or Devices Used to Solve or Organize Responses	**Conditions for Use In Instruction and Assessment**
2-G: Respond on Test Book	I, A
2-H: Monitor Test Response	I, A
2-J: Mathematics Tools and Calculation Devices*	I, A
2-K: Spelling and Grammar Devices*	I, A[4]
2-L: Visual Organizer	I, A[5]
2-M: Graphic Organizer	I, A
2-N: Computer Access Tools/Devices/Software*	I, N/A
2-O: Writing Tools/Implements*	I, A
Other Response Accommodations	**Conditions for Use In Instruction and Assessment**
2-P: Unique	Determined on a case-by-case basis in consultation with MSDE

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

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

Document basis for decision:

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

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____

Name: Agency: IEP Team Meeting Date: / /

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

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

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

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

Document basis for decision: ______________________________

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

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

Document basis for decision:

____

____

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

Document basis for decision: ______________________________

Name: Agency: IEP Team Meeting Date: / /

SUPPLEMENTARY AIDS, SERVICES, PROGRAM MODIFICATIONS AND SUPPORTS

◯ Instructional Support(s)

Nature of Service	Frequency	Begin Date	End Date	Provider(s) Ⓟ = Primary, ◯ = Other
◯ 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 Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency________________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider__________________ Ⓟ ◯ Nurse Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Certified Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide

Clarify location and manner: ____

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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 Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency_________________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider___________________ Ⓟ ◯ Nurse	Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Certified Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide

Clarify location and manner: ____

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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 Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency_________________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider__________________ Ⓟ ◯ Nurse	Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Certified Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide

Clarify location and manner: ____

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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 Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency___________________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider___________________ Ⓟ ◯ Nurse	Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Certified Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide

Clarify location and manner: ____

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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 ◯ Travel training ◯ 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 Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency__________________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider___________________ Ⓟ ◯ Nurse Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Certified Occupational Therapy Assistant Ⓟ ◯ Physical Therapy Assistant Ⓟ ◯ Speech/Language Assistant Ⓟ ◯ Therapeutic Behavioral Aide

Clarify location and manner: ____

____

Documentation to Support Decision: ____

____

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

Discussion to support decision(s): ____

____

____

Name: Agency: IEP Team Meeting Date: / /

EXTENDED SCHOOL YEAR (ESY)

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

◯ ESY Decision Deferred

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

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

   Discussion to support decision: ____________________

   ____

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

   Discussion to support decision: ____________________

   ____

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

   Discussion to support decision: ____________________

   ____

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

   Discussion to support decision: ____________________

   ____

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

   Discussion to support decision: ____________________

   ____

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

   Discussion to support decision: ____________________

   ____

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

   Discussion to support decision: ____________________

   ____

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

Document basis for decision(s): ____________________

____

Name: Agency: IEP Team Meeting Date: / /

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

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

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

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

____

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

Employment (required): ______________________________

Training: ______________________________

Education: ______________________________

Independent Living (if appropriate): ______________________________

COURSE OF STUDY:

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

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

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

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

Discussion to support decision: ______________________________

PROJECTED CATEGORY OF EXIT:
The student will exit with: ○ Maryland High School Diploma
☐ with 2 credits of Foreign Language
☐ with 2 credits of Advanced Technology
☐ with 4 credits of Career and Technology Program
○ Certificate of Program Completion at the end of the school year the student turns 21
○ Certificate of Program Completion prior to the end of the school year the student turns 21 (Parent and student choice)

PROJECTED DATE OF EXIT:
The student is participating in a ______ year program and is projected to exit/graduate school ___________________ (month, day, year)

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

Name: Agency: IEP Team Meeting Date: / /

TRANSITION ACTIVITIES

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

Academic: ______________________________

____

Responsible Party: ______________________________

Employment Training: ______________________________

____

Responsible Party: ______________________________

Activities of Daily Living: ______________________________

____

Responsible Party: ______________________________

Independent Living: ______________________________

____

Responsible Party: ______________________________

Transportation: ______________________________

____

Responsible Party: ______________________________

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

AGENCY LINKAGE:

	*The student has been referred to:		*Agency Representatives were invited to the IEP Team meeting:			Anticipated Services for Transition:	
	Yes	No	Yes	No	N/A	Yes	No
Division of Rehabilitation Services (DORS)	○	○	○	○	○	○	○
Developmental Disabilities Administration (DDA)	○	○	○	○	○	○	○
Mental Hygiene Administration (MHA)	○	○	○	○	○	○	○

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

____

Discussion to support decision: ______________________________

____

Name: Agency: IEP Team Meeting Date: / /

GOAL ____________________

Goal: ____________________

By: ☐☐•☐☐•☐☐☐☐ (MM•DD•YYYY)

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

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

ESY goal? ○ YES ○ NO

Objective 1: ____________________

Objective 2: ____________________

Objective 3: ____________________

Objective 4: ____________________

Progress Toward Goal	
Progress Report 1 Date_______	Progress Code: ○ Achieved ○ Making sufficient progress to meet goal ○ 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 (IEP team needs to meet to address insufficient progress) 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 Hearing Impaired Ⓟ ○ Teacher of the Visually Impaired Ⓟ ○ Occupational Therapist Ⓟ ○ Pupil Personnel Worker Ⓟ ○ Physical Education Tchr Ⓟ ○ Rehabilitation Services Staff Ⓟ ○ General Education Tchr Ⓟ ○ Career & Technology Tchr Ⓟ ○ Department of Social Services (DSS) Ⓟ ○ Mental Hygiene Administration (MHA) Ⓟ ○ Developmental Disabilities Administration (DDA) Ⓟ ○ Division of Rehabilitation Services (DORS) Ⓟ ○ Other Agency________________________ Ⓟ ○ Special Education Classroom Teacher Ⓟ ○ Other Service Provider__________________	Ⓟ ○ Audiologist Ⓟ ○ Psychologist Ⓟ ○ IEP Team Ⓟ ○ Interpreter Ⓟ ○ Instructional Assistant Ⓟ ○ Physical Therapist Ⓟ ○ Home-Based Teacher Ⓟ ○ Guidance Counselor Ⓟ ○ School Social Worker Ⓟ ○ Recreational Therapist Ⓟ ○ Certified 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 Hearing Impaired Ⓟ ○ Teacher of the Visually Impaired Ⓟ ○ Occupational Therapist Ⓟ ○ Pupil Personnel Worker Ⓟ ○ Physical Education Tchr Ⓟ ○ Rehabilitation Services Staff Ⓟ ○ General Education Tchr Ⓟ ○ Career & Technology Tchr Ⓟ ○ Department of Social Services (DSS) Ⓟ ○ Mental Hygiene Administration (MHA) Ⓟ ○ Developmental Disabilities Administration (DDA) Ⓟ ○ Division of Rehabilitation Services (DORS) Ⓟ ○ Other Agency________________________ Ⓟ ○ Special Education Classroom Teacher Ⓟ ○ Other Service Provider__________________	Ⓟ ○ Audiologist Ⓟ ○ Psychologist Ⓟ ○ IEP Team Ⓟ ○ Interpreter Ⓟ ○ Instructional Assistant Ⓟ ○ Physical Therapist Ⓟ ○ Home-Based Teacher Ⓟ ○ Guidance Counselor Ⓟ ○ School Social Worker Ⓟ ○ Recreational Therapist Ⓟ ○ Certified 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:____

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Name: Agency: IEP Team Meeting Date: / /

SERVICES

◯ RELATED SERVICES

Service Nature	Location	Service Description			Begin Date	End Date	Provider(s) Ⓟ = Primary, ◯ = Other		Summary of Service
◯ Audiological Services ◯ Psychological Services ◯ Occupational Therapy ◯ Physical Therapy ◯ Recreation ◯ Early Identification &Assessment ◯ Counseling Services ◯ School Health Services ◯ Social Work Services ◯ Parent Counseling & Training ◯ Rehabilitative Counseling ◯ Orientation & Mobility Training Services ◯ Assistive Technology Services ◯ Medical Services (Diagnostic & Evaluation) ◯ Other Therapies ____________ ◯ Interpreting Services ◯ Speech/Language Therapy ◯ 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 Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency____________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider________________ Ⓟ ◯ Nurse	Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Certified 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 ◯ Assistive Technology 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 Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency____________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider________________ Ⓟ ◯ Nurse	Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Certified 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: ______________________________

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
		Number of Sessions	Length of Time	Frequency					
◯ Career and Technology Education Program w/Support Services ◯ Vocational Evaluation ◯ Special Education Program with Pre-Vocation Objectives	◯ In General Education ◯ Outside General Education	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Other ____	____ Hours ____ Minutes	◯ 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 Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency____________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider____________________	Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Certified 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
		Number of Sessions	Length of Time	Frequency					
◯ Career and Technology Education Program w/Support Services ◯ Vocational Evaluation ◯ Special Education Program with Pre-Vocation Objectives	◯ In General Education ◯ Outside General Education	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Other ____	____ Hours ____ Minutes	◯ 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 Hearing Impaired Ⓟ ◯ Teacher of the Visually Impaired Ⓟ ◯ Occupational Therapist Ⓟ ◯ Pupil Personnel Worker Ⓟ ◯ Physical Education Tchr Ⓟ ◯ Rehabilitation Services Staff Ⓟ ◯ General Education Tchr Ⓟ ◯ Career & Technology Tchr Ⓟ ◯ Department of Social Services (DSS) Ⓟ ◯ Mental Hygiene Administration (MHA) Ⓟ ◯ Developmental Disabilities Administration (DDA) Ⓟ ◯ Division of Rehabilitation Services (DORS) Ⓟ ◯ Other Agency____________________ Ⓟ ◯ Special Education Classroom Teacher Ⓟ ◯ Other Service Provider____________________	Ⓟ ◯ Audiologist Ⓟ ◯ Psychologist Ⓟ ◯ IEP Team Ⓟ ◯ Interpreter Ⓟ ◯ Instructional Assistant Ⓟ ◯ Physical Therapist Ⓟ ◯ Home-Based Teacher Ⓟ ◯ Guidance Counselor Ⓟ ◯ School Social Worker Ⓟ ◯ Recreational Therapist Ⓟ ◯ Certified 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:____

____

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):

- ☐ 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
- ☐ SEPARATE CLASS ☐ PRIVATE SEPARATE DAY SCHOOL ☐ PRIVATE RESIDENTIAL FACILITY ☐ SERVICE PROVIDER LOCATION
- ☐ PUBLIC SEPARATE DAY SCHOOL ☐ PUBLIC RESIDENTIAL FACILITY ☐ HOME

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

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

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

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

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

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

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

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

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

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

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

______

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

______

SSIS Residence County______ SSIS Residence School ______
SSIS Service County ______ SSIS Service School______

CHILD COUNT ELIGIBILITY CODES

- ☐ (1) Eligible student with a disability served in a public school or placed in a nonpublic school by the public agency to receive FAPE.
- ☐ (2) Eligible parentally placed private school student with a disability receiving special education and/or related service through a service plan from the public agency.
- ☐ (3) Eligible parentally placed private school student with a disability NOT receiving service from the public agency.
- ☐ (4) Eligible public school student with a disability not receiving services due to parent refusal of initial services.
- ☐ (6) Eligible student with a disability prior to age 3. Parent Consent-Continue Early Intervention Services through an IFSP.

AUTHORIZATION(S)

CONSENT FOR INITIATION OF SERVICES (initial IEP only)

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

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

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

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

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

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

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

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

Parent Signature: ____ **Date:** ____________________

MEDICAL ASSISTANCE (MA)

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

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

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

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

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

Is the student eligible for MA? ○ Yes ○ No **MA Number** ________________________

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

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

MA Service Coordinator Name: ________________________________

MA Service Coordinator Name: ________________________________

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

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

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

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

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

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

Parent Signature: ________________________________ **Date:** ________________