Form 5 - Individualized Education Program (IEP)

School District: _____ **Annual Meeting Date**: ____/____/____

IEP Case Manager: _____**Effective date of Revision**: ____/____/____

Next 3-year Re-evaluation Date: ____/____/____ **Next Annual Review Date**: ____/____/____

Student/Child's Name: _____ Date of Birth: ____/____/____

Disability Category: _____ Child Count ID #: _____

School or Program: _____ Grade Assigned: _____

Parent/Guardian: _____ Telephone #: _____

Address: _____

Initiation and Duration of the IEP: ____/____/____ to ____/____/____

____/____/____ to ____/____/____

Initiation and Duration of Extended Year: ____/____/____ to ____/____/____

IEP Team Members	Printed Name/Position/Agency (check box if in attendance)
Name:	☐ Parent(s)/Guardian/Surrogate/Adult Student (circle one)
Name:	☐ Student (when appropriate)
Name:	☐ Local Education Agency (LEA) Representative
Name:	☐ Special Education Teacher or Service Provider
Name:	☐ General Education Teacher
Name	☐ Individual who can interpret the instructional implications of evaluation results
Name:	☐ Individual who can conduct diagnostic Examinations (SLD requirement)

Others with knowledge of the child*	Position/Agency
Name:	
Name:	
Name:	

***Including individuals for Part C Early Intervention or Post-Secondary Transition Planning**

Individualized Education Program
Present Levels of Educational and Functional Performance

Student Name: _____ IEP Meeting Date: ____/____/____

This section should provide a concise overview of student's current skills and serve as the basis of the student's program for the upcoming year. Describe **the student's present levels of educational performance including the student's functional performance, abilities, acquired skills and strengths relative to standards and/or grade level expectations**. Briefly highlight how the disability affects the student's involvement and progress in the general curriculum or, for preschool children, participation in age appropriate activities. As appropriate, address the following areas.

DISABILITY/IMPACT ON STUDENT LEARNING: (*Identify the disability and areas of impact, e.g., academic, social-emotional, behavioral*)

MEDICAL: (*Health, vision, hearing, or other medical issues*)

STUDENT STRENGTHS: (*Academic, social-emotional, personal interests, perceptual-motor, communication, environment*)

STUDENT NEEDS: (*Academic, social-emotional, perceptual-motor, communication, environment*)

OTHER CONSIDERATIONS: (*Areas to consider that could enhance the child's education: safety/health; future, opportunity for additional student or family input, mobility, transportation, disability awareness, self-advocacy needs*)

IEP for _____ IEP Meeting Date: _____/_____/_____

Present Level of Educational/Functional Performance for the Area of: _____

Standardized Test Results:

Current Classroom Level of Educational Performance:

Current Classroom Level of Functional Performance:

Grade Expectation for Educational/Functional Performance:

Measurable annual goals, short-term Objectives, Benchmarks, Evaluation Procedures and Personnel Responsible	**Progress Review Dates/Code**

Progress Review Dates Code: **A –** Achieved the goal/objective as written; **S** – Sufficient progress on objective is being made; likely to achieve this goal; **E** – Emerging progress on the objective, continuing to work towards the goal; **N** – Objective/goal not yet introduced

IEP for _____ **IEP Meeting Date**: _____/_____/_____

Measurable annual goals, short-term Objectives, Benchmarks, Evaluation Procedures and Personnel Responsible	**Progress Review Dates/Code**

Progress Review Dates Code: **A –** Achieved the goal/objective as written; **S** – Sufficient progress on objective is being made; likely to achieve this goal; **E** – Emerging progress on the objective, continuing to work towards the goal; **N** – Objective/goal not yet introduced

Individualized Education Program
Post-Secondary Transition Plan, Page One

As of August 2020, this version of the IEP Post-Secondary Transition Plan has been discontinued. Please refer to the updated templated found here.

Individualized Education Program
Special Education Services, Related Services, Consent to Bill Medicaid

Student Name: _____ IEP Meeting Date: ____/____/____

Special Education Services	Init Date	End Date	Freq	Time	Location	Provider	Group Size
Reading Comprehension	*4-28 2010*	*4-27 2011*	*5x wk*	*30 min*	*Resource Room*	*Special Educator*	*Sm Group*
(For EEE, one or more of the five domains)							
Cognitive Development	*4-28 2010*	*4-27 2011*	*3x wk*	*20 min*	*Early Childhood Program*	*Essential Early Educator*	*1:1*

Related Services	Init Date	End Date	Freq	Time	Location	Provider	Group Size
Speech Therapy	*4-28 2010*	*6-18 2010*	*2x*	*30 min*	*Therapist's Room*	*SLP*	*1:1*

Transition Services	Init Date	End Date	Freq	Time	Location	Provider	Group Size
Job Coach	*8-27 2010*	*4-27 2011*	*5x*	*120 min*	*Community Employment*	*Paraeducator*	*1:1*

Extended School Year Services	Init Date	End Date	Freq	Time	Location	Provider	Group Size
Reading Comprehension	*7-6 2010*	*8-5 2010*	*3x*	*30 min*	*Resource Room*	*SLP*	*1:1*

Parental Consent to Bill Medicaid: For parents and legal guardians who have signed a Release of Information form, the school district is authorized to bill Medicaid for the services listed in this Individualized Education Program and to release any necessary special education records to a physician/nurse practitioner in order for them to reach a determination that the services are medically necessary. Release of information is also granted to Agency of Education and Human Services personnel charged with processing Medicaid billing for those IEP services that are also considered medical services under Vermont Medicaid rules. This consent will remain in effect until consent is revoked or until the student reaches the age of 18 (at which time consent must be obtained from the student) or when the student graduates. Refusal to consent does not affect the school district's responsibility to provide these services to the student at no cost to the family. I understand that I may revoke consent at any time and when I revoke consent it will apply to billing for any services from that date forward.

Individualized Education Program

Educational Environment/Placement, Accommodations/Modifications for Assessments

Student Name: _____ IEP Meeting Date: ____/____/____

If the student cannot participate full-time with non-disabled children in the general education class, extracurricular or other non-academic activities explain why full participation is not possible:

Description of the student/child's educational environment/placement:

The general characteristics of the student/child's educational environment/placement (check one, ages 6-21):

- ❒ Inside regular class at least 80% of the time
- ❒ Inside regular class less than 40% of the time
- ❒ Residential facility
- ❒ Inside regular class 40% to 79% of the time
- ❒ Separate day school – public or private
- ❒ Homebound/Hospital

The general characteristics of the child's educational environment/placement (ages 3-5):

❒ Child is attending a regular early childhood program 10 or more hours per week.
- □ and receives at least 50% of their special education services in the regular early childhood program
- □ and receives at least 50% of their special education services in some other location

❒ Child is attending a regular early childhood program less than 10 hours per week
- □ and receives at least 50% of their special education services in the regular early childhood program
- □ and receives at least 50% of their special education services in some other location

❒ Child is not attending a regular early childhood program and receives special education services in:
- □ a separate special class
- □ a separate school
- □ a residential facility
- □ their home
- □ the service provider's location or another location

Accommodations, Modifications and Supplementary Aids

State-level assessment (please check appropriate box or boxes):

☐ The team has determined that the student will be taking the on-level State assessment with no accommodations, modifications or supplementary aids.

☐ The team has determined that the student will be taking the on-level State assessment with the approved accommodations, modifications or supplementary aids identified below.

☐ The student's educational team has completed the required eligibility form(s) and has determined that the student will participate in the alternate assessment based on alternate achievement standards (AA-AAS). Check all that apply.

- ❒ Dynamic Learning Maps English Language Arts (grades 3-8, 11)
- ❒ Dynamic Learning Maps Mathematics (grades 3-8, 11)
- ❒ Vermont Alternate Assessment Portfolio (VTAAP) for Science (grades 4, 8, 11)

Identify the accommodations, modifications and supplementary aids and services needed to participate in national, state, district-wide, and school assessments:

Program Modifications/Supports for the Student, School Personnel and Parents as well as Other Options Considered by the IEP Team

Student Name: _____ IEP Meeting Date: ____/____/____

Identify other accommodations, modifications, or supplementary aids (such as extended time, assistive technology, peer tutors) and services needed for the student:

❒ The IEP Team has determined that the student is eligible for the supports of Accessible Instructional Materials which have met the National Instructional Materials Accessibility Standards for print disabilities.

Identify the program modifications or supports that will be provided for school personnel and parents to implement the IEP:

Other Options Considered (include reasons why they were not included):