SOUTH EAST CONSORTIUM SELPA
INDIVIDUALIZED EDUCATION PROGRAM

Student Name _____ **Date of Birth** ___/___/_____ **IEP Date** ___/___/_____
Last IEP ____ / ____ / _____ Next IEP ____ / ____ / _____ Original SpEd Entry Date ___/___/_____
Last Eval ____ / ____ / _____ Next Eval ____ / ____ / _____

Purpose of Meeting ☐Initial ☐Annual ☐Triennial ☐Transition ☐Pre-Expulsion ☐Interim ☐Other_____

Age _____ Gender _____
Grade _____ Migrant ☐Yes ☐No Native Language _____
EL ☐Yes ☐No Redesignated ☐Yes ☐ No Interpreter ☐Yes ☐No
Student ID _____ SSN _____ SSID _____

Residency ☐ Parent/Guardian ☐ Foster _____ ☐ LCI_____
☐ Adult Student ☐ Other _____

Parent / Guardian _____ Home Phone _____
Home Address _____ Work Phone _____
City _____ Cell Phone _____
State, Zip _____ Email _____

Parent / Guardian _____ Home Phone _____
Home Address _____ Work Phone _____
City _____ Cell Phone _____
State, Zip _____ Email _____

Ethnicity (Select One) ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (Enter Code, must select one or more, regardless of Ethnicity): Race 1 _____ Race 2 _____ Race 3 _____

INDICATE DISABILITY/IES (P = Primary, S = Secondary) *Note: For Initial and triennial IEPs, assessment must be done and discussed by IEP Team before determining eligibility.*

_____ 210 ID _____ 220 HH * _____ 230 Deaf * _____ 240 SLI _____ 250 VI *
_____ 260 ED _____ 270 OI* _____ 280 OHI _____ 290 SLD _____ 300 DB *
_____ 310 MD _____ 320 AUT _____ 330 TBI _____ 281 Est. Med. Dis. (0-5)

* Low Incidence Disability

_____Not Eligible for Special Education _____Exiting from Sp. ED. (returned to reg. ed/no longer eligible)

Describe how student's disability affects involvement and progress in the general curriculum (or for preschoolers, participation in appropriate activities) _____
_____

FOR INITIAL PLACEMENTS ONLY

Has the student received IDEA Coordinated Early Intervening Services (CEIS) in the past two years? ☐ Yes ☐No
Date of Initial Referral for Special Education Services _____/_____/_____
Person Initiating the Referral for Special Education Services _____
Date District Received Parent Consent _____/_____/_____
Date of Initial Meeting to Determine Eligibility _____/_____/_____

SOUTH EAST CONSORTIUM SELPA
PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

Student Name _____ **Date of Birth ___/___/_____** **IEP Date ___/___/_____**

Strengths/Preferences/Interests _____

Concerns of parent relevant to educational progress _____

SBAC (Scores not available from 2014)

English/Language Arts	☐ Adv.	☐ Proficient	☐ Basic	☐ Below Basic	☐ Far Below Basic
Math	☐ Adv.	☐ Proficient	☐ Basic	☐ Below Basic	☐ Far Below Basic

CA Standards Test

Science	☐ Adv.	☐ Proficient	☐ Basic	☐ Below Basic	☐ Far Below Basic

CMA

Science	☐ Adv.	☐ Proficient	☐ Basic	☐ Below Basic	☐ Far Below Basic

CAPA

English/Language Arts	☐ Adv.	☐ Proficient	☐ Basic	☐ Below Basic	☐ Far Below Basic
Math	☐ Adv.	☐ Proficient	☐ Basic	☐ Below Basic	☐ Far Below Basic
Science	☐ Adv.	☐ Proficient	☐ Basic	☐ Below Basic	☐ Far Below Basic

CELDT

Listening _____ Speaking _____ Reading _____ Writing _____

Physical Education Testing (grades 5, 7 & 9): _____

Other Assessment Data (e.g., curriculum assessment, other district assessment, etc.) _____

Hearing	Date ___ / ___ / _____	☐ Pass ☐ Fail	☐ Other _____	
Vision	Date ___ / ___ / _____	☐ Pass ☐ Fail	☐ Other _____	

Preacademic/Academic/Functional Skills _____

Communication Development _____

Gross/Fine Motor Development _____

Social Emotional/Behavioral _____

Vocational_____

Adaptive/Daily Living Skills _____

Health _____

SOUTH EAST CONSORTIUM SELPA
PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

For student to receive educational benefit, goals will be written to address the following areas of need:

_____

_____

SOUTH EAST CONSORTIUM SELPA
SPECIAL FACTORS

Student Name _____ **Date of Birth** ___/___/_____ **IEP Date** ___/___/_____

Does the student require assistive technology devices and/or services? ☐Yes ☐No
Rationale_____
_____
_____

Does the student require low incidence services, equipment and/or materials to meet educational goals? ☐Yes ☐No
(if yes, specify) _____
_____
_____

Considerations if the student is blind or visually impaired: _____
_____
_____

Considerations if the student is deaf or hard of hearing: _____
_____
_____

If the student is an English Learner, complete the following section:

Does the student need primary language support? ☐Yes ☐No If yes, how will it be provided?
_____

What will be the language of instruction for the student? _____

Who will provide ELD services to student? ☐ General Education ☐Special Education

What type of classroom setting will the student attend?

☐ English Language Mainstream ☐Structured English Immersion ☐ Alternative Program (primary language instruction)

Comments: _____
_____
_____

Does student's behavior impede learning of self or others? ☐Yes ☐No
_____
_____
_____

If yes, specify positive behavior interventions, strategies, and supports _____
_____

☐Behavior Intervention Plan (BIP) Attached ☐Behavior Goal is part of this IEP

Student Name _____ **Date of Birth _____** **IEP Date ___/___/_____**

Indicate student's participation in the California Assessment of Student Performance and Progress (CAASPP) below:

English Language Arts (Grades 3-8, & 11)

- ☐ Out of testing range
- ☐ SBAC without Designated Supports or Accommodations
- ☐ SBAC with Designated Supports Embedded_____
- ☐ SBAC with Designated Supports Non-embedded_____
- ☐ SBAC with Accommodations Embedded_____
- ☐ SBAC with Accommodations Non-embedded_____
- ☐ SBAC with Accessibility Support (requires CDE Approval) _____
- ☐ Alternate Assessment

Math (Grades 3-8, & 11)

- ☐ Outside of testing grade range
- ☐ SBAC without Designated Supports or Accommodations
- ☐ SBAC with Designated Supports Embedded_____
- ☐ SBAC with Designated Supports Non-embedded_____
- ☐ SBAC with Accommodations Embedded_____
- ☐ SBAC with Accommodations Non-embedded_____
- ☐ SBAC with Accessibility Support (requires CDE Approval)_____
- ☐ Alternate Assessment

Science (Grades 5, 8 & 10)

- ☐ Out of testing range
- ☐ CST without Designated Supports or Accommodations
- ☐ CST with Designated Supports_____
- ☐ CST with Accommodations_____
- ☐ CMA without Designated Supports or Accommodations
- ☐ CMA with Designated Supports_____
- ☐ CAPA Level 1.☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐

☐ If student is taking CMA, CAPA, or Alternate Assessment the IEP team has reviewed the criteria for taking alternate assessments.

The student will not participate in the SBAC because:

_____

Participation in an Alternate Assessment is appropriate because:

_____

Physical Fitness Test (Grades 5, 7, 9 only)

- ☐ Out of testing range
- ☐ Without accommodations
- ☐ With accommodations_____
- ☐ With modifications (Check with PFT Office prior to use)_____

CAHSEE

- ☐ Outside of testing range
- ☐ Without accommodations
- ☐ With accommodations_____
- ☐ CAHSEE with modifications (waiver required) _____

☐ Exemption/ Medical Exemption_____
☐ To participate in Alternate Assessment

☐ **Other State-Wide/ District-Wide Assessment(s) Alternate Assessment**(s) _____

Desired Results Developmental Profile (**DRDP) –** (For Preschoolers Ages 3, 4 and 5 years)

☐ Not Applicable ☐ Sensory support ☐ Functional positioning
☐ Alternative response mode ☐ Assistive equipment or device ☐ Visual support
☐ Alternative mode for written language ☐ Augmentative or alternative communication system

☐ **CELDT** (English Learners Only)
☐ Listening without accommodations
☐ Listening with accommodations_____

☐ Speaking without accommodations
☐ Speaking with accommodations_____

☐ Reading without accommodations
☐ Reading with accommodations_____

☐ Writing without accommodations
☐ Writing with accommodations_____

☐ **Alternate Assessment to CELDT**
If yes, areas of alternate assessment: ☐ Listening ☐ Speaking ☐ Reading ☐ Writing
Person responsible to administer alternate assessment(s) _____

☐ **Standards based Tests in Spanish (STS)**
☐ Math without accommodations
☐ Math with accommodations_____
☐ Reading, Language, Spelling without accommodations
☐ Reading, Language, Spelling with accommodations_____

SOUTH EAST CONSORTIUM SELPA
ANNUAL GOALS

Student Name _____ **Date of Birth ___/___/_____** **IEP Date ___/___/_____**

Area of Need	Measurable Annual Goal # _____
	☐ Enables student to be involved/progress in general curriculum/state standard
Baseline	☐ Addresses other educational needs resulting from the disability
	☐ Linguistically appropriate
	☐ Transition Goal: ☐ Education/Training ☐ Employment ☐ Independent Living
	Person(s) Responsible _____

Goal
_____
_____

Progress Report 1 Date ____ / ____ / _____

Summary of Progress _____
_____

Comments _____
_____

Progress Report 2 Date ____ / ____ / _____

Summary of Progress _____
_____

Comments _____
_____

Progress Report 3 Date ____ / ____ / _____

Summary of Progress _____
_____

Comments _____
_____

Annual Review Date ____ / ____ / _____

Goal Met ☐Yes ☐No

Comments _____
_____

SOUTH EAST CONSORTIUM SELPA
Offer of FAPE - Services

Name _____ Birthdate _____/_____/_____ IEP Date _____/_____/_____

The service options that were considered by the IEP team (List all):_____

_____

_____

In selecting LRE, describe the consideration given to any potential harmful effect on the child or on the quality of services that he or she needs:

_____

_____

SUPPLEMENTARY AIDS, SERVICES & OTHER SUPPORTS FOR SCHOOL PERSONNEL, OR FOR STUDENT, OR ON BEHALF OF THE STUDENT

Aids, Services, Program Accommodations/Modifications, and/or Supports		Start Date	End Date	Frequency	Duration	Location
	☐ Student	/ /	/ /			
	☐ Personnel	/ /	/ /			
	☐ Student	/ /	/ /			
	☐ Personnel	/ /	/ /			
	☐ Student	/ /	/ /			
	☐ Personnel	/ /	/ /			

Special Education Transportation ☐ No ☐ Yes _____

SPECIAL EDUCATION and RELATED SERVICES

Service		Start Date / /	End Date / /
Provider			☐ Ind ☐ Grp ☐ Sec Transition
Frequency	**Duration**	**Location**	
Comments:			
Service		Start Date / /	End Date / /
Provider			☐ Ind ☐ Grp ☐ Sec Transition
Frequency	**Duration**	**Location**	
Comments:			
Service		Start Date / /	End Date / /
Provider			☐ Ind ☐ Grp ☐ Sec Transition
Frequency	**Duration**	**Location**	
Comments:			

Programs and services will be provided according to where student is in attendance and consistent with the district of service calendar and scheduled services, excluding holidays, vacations, and non-instructional days unless otherwise specified.

SOUTH EAST CONSORTIUM SELPA
Offer of FAPE - Services

EXTENDED SCHOOL YEAR (ESY)

☐ **Yes** ☐ **No** Rationale_____

Service		Start Date / /	End Date / /
Provider			☐ Ind ☐ Grp ☐ Sec Transition
Frequency	**Duration**	**Location**	
Service	**Start Date / /**	**End Date / /**	
Provider			☐ Ind ☐ Grp ☐ Sec Transition
Frequency	**Duration**	**Location**	
Service	**Start Date / /**	**End Date / /**	
Provider			☐ Ind ☐ Grp ☐ Sec Transition
Frequency	**Duration**	**Location**	

SOUTH EAST CONSORTIUM SELPA
OFFER OF FAPE - EDUCATIONAL SETTING

Student Name _____ **Date of Birth** ___/___/_____ **IEP Date** ___/___/_____

Physical Education ☐ General ☐ Specially Designed ☐ Other _____

District of Service _____ School of Attendance _____ School Type _____

Federal Setting _____ Federal Preschool Setting _____

All special education services provided at student's school of residence? ☐ Yes ☐ No (rationale) _____

_____% of time student is outside the regular class & extracurricular & non academic activities

_____% of time student is in the regular class & extracurricular & non academic activities

Student will not participate in the regular class and/or extracurricular and/or non academic activities _____
because _____
_____

Other Agency Services

☐ California Children's Services (CCS)
☐ Regional Center
☐ Probation
☐ Department of Rehabilitation
☐ Department of Social Services (DSS)
☐ County Mental Health (CMH)
☐ Other _____

Promotion Criteria ☐ District ☐ Progress on Goals ☐ Other _____

Parents will be informed of progress ☐ Quarterly ☐ Trimester ☐ Semester ☐ Other _____

How? ☐ Progress Summary Report ☐ Other _____

ACTIVITIES TO SUPPORT TRANSITION (e.g., preschool to kindergarten, special education and/or NPS to general education class, middle school to high school)

_____
_____
_____

GRADUATION PLAN (Grade 7 and Higher)

Projected graduation date and/or secondary completion date ___/___/_____

☐ To participate in curriculum leading to a Diploma
☐ To participate in curriculum leading to a Certificate of Completion

SOUTH EAST CONSORTIUM SELPA

Parent Consent

Student Name _____ **Date of Birth** ___/___/_____ **IEP Date** ___/___/_____

IEP MEETING PARTICIPANTS

_____ Parent / Guardian / Surrogate	___/___/_____ Date	_____ Parent / Guardian	___/___/_____ Date
_____ Student / Adult Student	___/___/_____ Date	_____ General Education Teacher	___/___/_____ Date
_____ LEA Representative/Admin. Designee	___/___/_____ Date	_____ Special Education Specialist	___/___/_____ Date
_____ Additional Participant/Title	___/___/_____ Date	_____ Additional Participant/Title	___/___/_____ Date
_____ Additional Participant/Title	___/___/_____ Date	_____ Additional Participant/Title	___/___/_____ Date
_____ Additional Participant/Title	___/___/_____ Date	_____ Additional Participant/Title	___/___/_____ Date

CONSENT

_____ I agree to all parts of the IEP.

_____ I agree with the IEP, with the exception of _____

_____ I decline the offer of initiation of special education services.

_____ I understand that my child is <u>not</u> eligible for special education.

_____ I understand that my child is <u>no longer</u> eligible for special education

As a means of improving services and results for your child did the school facilitate parent involvement? ☐Yes ☐No ☐No Response

Signature below is to authorize and approve the IEP.

Signature_____ ___/___/_____

☐Parent ☐ Guardian ☐Surrogate ☐Adult Student Date

Signature_____ ___/___/_____

☐Parent ☐ Guardian ☐Surrogate ☐Adult Student Date

If my child is or may become eligible for public benefits (Medi-Cal): I authorize the LEA/district to release student information for the limited purpose of billing Medi-Cal/Medicaid and to access Medi-Cal: health insurance benefits for applicable services.

Signature _____

☐Parent ☐ Guardian ☐Surrogate ☐Adult Student

☐Parent /Adult student has received a copy of the Procedural Safeguards

☐Parent /Adult student has received a copy of assessment report (if applicable)

☐Parent/Adult student has received a copy of Individualized Education Plan (IEP)

☐Parent/Adult student has received written notification of protections available to parents when LEA requests to access Medi-cal benefits

☐Student enrolled in private school by their parents. Refer to Individual Service Plan, if appropriate.

☐Student enrolled in private school by their parents. Refer to Individual Service Plan, if appropriate.

SOUTH EAST CONSORTIUM SELPA
IEP TEAM MEETING NOTES

Student Name _____ **Date of Birth ___/___/_____** **IEP Date ___/___/_____**

Comments _____