

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) <input type="checkbox"/>
Name:	Student (when appropriate) <input type="checkbox"/>
Name:	Local Education Agency (LEA) Representative <input type="checkbox"/>
Name:	Special Education Teacher or Service Provider <input type="checkbox"/>
Name:	Early Childhood Education Teacher <input type="checkbox"/>
Name:	Individual who can interpret the instructional implications of evaluation results <input type="checkbox"/>
Name:	Individual who can conduct diagnostic Examinations (SLD requirement) <input type="checkbox"/>

Others with knowledge of the child*	Position/Agency
Name:	<input type="checkbox"/>
Name:	<input type="checkbox"/>
Name:	<input type="checkbox"/>
Name:	<input type="checkbox"/>
Name:	<input type="checkbox"/>
Name:	<input type="checkbox"/>
Name:	<input type="checkbox"/>

***Include individuals from Part C Early Intervention if child is transitioning from Part C to B at age 3.**

**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, describe how the child's disability affects his/her access to and participation in age appropriate activities**. As appropriate, address the following areas.

Briefly describe the child's abilities and interests (who they are as an individual) and how their developmental delay or medical condition affects their access to and participation in age appropriate activities.

MEDICAL History: *(physical, hearing, vision, CDC report, etc.)*

Child STRENGTHS: *(consider the child's strengths/interests across the three early childhood outcome (ECO) areas: getting needs met, acquiring new knowledge, social-emotional skills-relationships and engagement)*

- A. Social emotional skills and relationship:**
- B. Acquiring new knowledge and skills:**
- C. Getting needs met:**

Child CONCERNS: *(consider concerns across the three early childhood outcome (ECO) areas: getting needs met; acquiring knowledge; social-emotional skills- relationships and engagement) If behavior is a concern, has a functional behavior assessment* been conducted?*

- A. Social emotional skills and relationship:**
- B. Acquiring new knowledge and skills:**
- C. Getting needs met:**

Child NEEDS: *Consider and prioritize the necessary supports for the child to access and participate in a regular early childhood setting and age appropriate activities with his/her same-age peers?*

- A. Social emotional skills and relationship**
- B. Acquiring new knowledge and skills:**
- C. Getting needs met:**

OTHER CONSIDERATIONS: *(Areas to consider that could enhance the child's educational opportunities: safety/health, school district partnerships with community-based early childhood programs (Act 62), private early childhood programs, home-visiting, community-based child and family resources (Children's Integrated Services), transportation, disability awareness, advocacy needs)*

*Foundations for Early Learning (FEL) Functional Behavior Assessment Forms can be located on-line at [www._____](http://www._____.)

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

Global outcome/Goal area:

Please check which developmental area you are addressing: social/emotional adaptive communication fine/gross motor cognitive skills

Current developmental skill level:

Current functional ability: (Consider how the child uses discrete skills (as listed above) in a meaningful, intentional and functional way in the context of everyday activities, routines and transitions. Focus on the child's engagement, approaches to learning and independence in developmentally appropriate activities across a variety of settings.)

Early Childhood Outcome culminating statement for this outcome area is required upon entry and exit of EEE services. (add drop down bucket list) Buckets will be converted to COSFrating which appears on page ____ of this document. ▾

Vermont Early Learning Standards: ▾

Short-term Objectives, Benchmarks, Evaluation Procedures and Personnel Responsible	Progress Review Dates
	<p>Progress is reported as often as the school district conducts parent/teacher conferences or as determined by the IEP team..</p> <p>Date of review:</p> <p>After reviewing the outcome/goal and progress monitoring data, we, the team, have decided: (Check one)</p> <p><input type="checkbox"/> We still need to work toward this outcome/goal. <i>Let's continue with what we have been doing.</i></p> <p><input type="checkbox"/> We still need to work toward this outcome/goal. <i>Let's discuss new ways to get there.</i></p> <p><input type="checkbox"/> The situation has changed; we no longer need to work on this outcome/goal.</p> <p><input type="checkbox"/> We are satisfied that the child has mastered this outcome/goal.</p> <p><input type="checkbox"/> Other:</p>

IEP for _____

IEP Meeting Date: ____/____/____

Global outcome/Goal area cont'd: _____

Short-term Objectives, Benchmarks, Evaluation Procedures and Personnel Responsible

Progress Review Dates

(This area contains a large 'DRAFT' watermark)

Date of review:

After reviewing the outcome/goal and progress monitoring data, we, the team, have decided:

(Check one)

We still need to work toward this outcome/goal.

Let's continue with what we have been doing.

We still need to work toward this outcome/goal.

Let's discuss new ways to get there.

The situation has changed; we no longer need to work on this outcome/goal.

We are satisfied that the child has mastered this outcome/goal.

Other:

(This area contains a large 'DRAFT' watermark)

Date of review:

After reviewing the outcome/goal and progress monitoring data, we, the team, have decided:

(Check one)

We still need to work toward this outcome/goal.

Let's continue with what we have been doing.

We still need to work toward this outcome/goal.

Let's discuss new ways to get there.

The situation has changed; we no longer need to work on this outcome/goal.

We are satisfied that the child has mastered this outcome/goal.

Other:

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

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

The IEP team determines the special education, related services, and supplementary aids and services based on peer reviewed research, to the extent practical, that are needed for the child to receive FAPE.

Special Education Services <i>(Specify global outcome area addressed)</i>	Init Date	End Date	Freq	Time	Location	Provider	Group Size

Related Services	Init Date	End Date	Freq	Time	Location	Provider	Group Size

Extended School Year Services	Init Date	End Date	Freq	Time	Location	Provider	Group Size

Parental Consent to Bill Medicaid

As the parent/guardian, I give permission or do not give permission to the school district to bill Medicaid for the eligible services listed above. This permission also allows the release of necessary special education records to a physician or nurse practitioner in order for him/her to reach a determination that the services are medically necessary; as well as to individuals within the Department of Education and the Agency of Human Services charged with processing Medicaid bills for those services above that are considered medical services under Vermont Medicaid rules. I understand that if I refuse to consent, my refusal will not affect the school district's responsibility to provide these services to my child at no cost to me. I understand that I may revoke this consent at any time and, if I revoke this consent, it will apply to billing for services from that date forward.

**Individualized Education Program
Educational Environment/Placement**

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

An explanation of the extent, if any, to which the preschooler will not participate with children without disabilities in a regular early childhood setting and in age appropriate activities.

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

The general characteristics of the child's early childhood education 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/or Supplementary Aids

Identify environmental accommodations, curriculum modifications, supplementary aids etc. that will support the child's access to and participation in a regular early childhood setting.

**Program Modifications/Supports for the Child, Preschool Personnel and
Parents as well as Other Options Considered by the IEP Team**

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

Individualized Education Program PreK (Act 62) Assessment and Early Childhood Outcomes

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

PreK (Act 62) Assessment and Early Childhood Outcomes Reporting (please check appropriate box or boxes)

For VT DOE reporting purposes, the IEP team has determined that the child's annual progress will be assessed using the GOLD (required statewide PreK assessment measurement)

For VT DOE reporting purposes, the IEP team has determined that the child's annual progress will be assessed using an alternative assessment measure i.e., Battelle Developmental Inventory, Transdisciplinary Play-based Assessment, etc.

Early Childhood Outcomes Entry, Exit and Progress Data Collection

(generated from drop down bucket list)

For reporting purposes only

Outcome Area	Entry	Annual Review	Annual Review	Annual Review	Exit	Progress at exit?
A. Positive Social Emotional Skills						▼
B. Acquiring new knowledge/skills						▼
C. Getting Needs Met						▼

Sample (Name) Outcome Summary

