Macomb Intermediate School District
44001 Garfield Rd
Clinton Township, MI 48038-1100
Phone: (586) 228-3300

Individualized Education Program (IEP)

IEP Date:		**Purpose of IEP Meeting:** **Additional Purpose:**	
Student Name:	**UIC:**	**DOB:**	**Age:** years and month(s)
Gender:	**Resident District:**	**Attending District:**	
Attending School:	**Previous IEPT Date:**	**Grade:**	

Primary Language:		**Ethnicity:**	
Student's Address:	**City:**	**State:**	**Zip Code:**
County:		**Home Phone:**	**E-mail:**
Parent's Name:		**Relationship:**	
Language Spoken in the home:		**Interpreter Needed?:** ☐Yes ☐No	
Address (if different):	**City:**	**State:**	**Zip Code:**
Telephone:	**Telephone:**	**Telephone:**	**Email:**

IEP Team Participants in Attendance

Student is to be invited (if appropriate, but not later than age 16). A MET Evaluator is required at initial IEPs.

can explain the results of assessments.

☐	The Student:	☐	District Representative/Designee:
☐	Parent/Guardian:	☐	General Education Teacher:
☐	Parent/Guardian:	☐	Special Education Teacher:
☐	Other (with title):	☐	Agency Providing Transition Services (Age 16+):
☐	Other (with title):	☐	Other (with title):
☐	Other (with title):	☐	Other (with title):

Parent & District Agreement on Attendance Not Necessary: these members are absent because their curricular area/related services are not being modified or discussed in the meeting:

Parent & District Agreement on Excusal Prior to Meeting: these members are absent but have submitted their written input to parent & IEP Team for IEP development prior to the meeting:

Eligibility for Special Education and Qualifying Criteria

The student is: ☐Eligible ☐Not Eligible (Commitment/Notice Section must be completed)

Primary Eligibility

Student Name: **IEP Date:**

Student Summary
Describe the student's **strengths**: .
Describe the **parent concerns** for enhancing student's education: .
Describe the student's **developmental and functional needs**: .
Describe the student's **progress toward current IEP annual goals** and objectives (Omit at initial IEPT meeting): .
Describe the student's **progress in the general education classroom,** including **success of agreed-upon modifications** and student/teacher supports: .
Describe the student's **anticipated needs** of other matters: (e.g. high school credits, cohort group, curriculum planning, etc.): .

Student Name: **IEP Date:**

Present Level of Academic Achievement and Functional Performance (PLAAFP)			
Area or Domain	**Sub-Area**	**Present Performance Levels/Strengths** **Include recent assessment data. Explain how data establishes a beginning instruction point.**	**Describe how the student's disability affects the student's involvement and progress in the general education curriculum. For preschool children, as appropriate, how the disability affects the child's or student's involvement in age-appropriate activity.**
Reading		.	.
Writing		.	.
Mathematics		.	.
Communication: Speech & Language		.	.
Socio-Emotional/Behavioral		.	.
Perception/Motor/Mobility		.	.
Medical/Health/Physical		.	.
Adaptive/Independent Living		.	.
Transition (age 16+)		.	.
Cognitive		.	.

Student Name: **IEP Date:**

Consideration of Special Factors		
a)	**Does . have behavior which impedes his learning or the learning of others?**	☐Yes ☐No
b)	**Does . have limited English proficiency?**	☐Yes ☐No
c)	**Does . have blindness or visual impairment?**	☐Yes ☐No
d)	**Did you consider .'s communication needs?**	☐Yes ☐No
	Is . deaf or hard of hearing?	☐Yes ☐No
e)	**The IEP Team has considered whether . needs Assistive Technology devices and services in order to progress toward his goals and objectives and determined that:**	
	1. ☐ Assistive Technology is necessary. 2. ☐ It has not yet been determined whether . needs AT in order to progress toward his IEP goals and objectives. The Team plans to make this decision in the following way: 3. ☐ Assistive Technology is not necessary at this time.	
f)	**Does . have health, physical, and/or medical issues that may impact learning?**	☐Yes ☐No
g)	**Does . have any perceptual, motor, or mobility concerns, such as gross and fine motor coordination, balance, and limb/body mobility that impedes learning.**	☐Yes ☐No

Student Name: **IEP Date:**

Supplementary Aids and Supports

Supports and Modifications to the Environment, Behavior Training Needs, Social Interaction Supports for the Student, Health-Related Needs, Physical Needs, Transitioning Times, Assistive Technology, Training Needs, Guidance.

Area	Aids or Supports	Frequency/Conditions Circumstances	Location/Setting	Start Date (if different from IEP)	End Date (if different from IEP)
.	.	.	.		

Student Name: **IEP Date:**

Personal Care Services

Does the student have a chronic condition(s) that requires **Personal Care Services** (identified below) to enable him to accomplish Activities of Daily Living (ADL) in the area(s) checked here: ☑ Yes ☐ No

		Time, Frequency, Conditions, Circumstances	Location/Setting
☑	Eating/Feeding/Meal Preparation		
☑	Respiratory Assistance		
☑	Toileting/Maintenance Continence		
☑	Mobility/Positioning, Ambulation, Transferring		
☑	Bathing/Dressing/Grooming/Skin-Care/Personal Hygiene		
☑	Assistance with Self-Administered Medications		
☑	Redirection & Intervention for Behavior		
☑	Health-Related Functions (via hands-on Assistance, Supervision, Cueing)		
☑	Intervention for Seizure Disorder		

Student Name: . IEP Date:

Annual Goals

Area Of Need:

Content Expectations On Which This Goal Will Be Based::

Baseline Data:

Annual Goal:

Short-Term Objective:

Position(s) Responsible for Implementing these Goal Activities:

Performance Criteria:	Evaluation Procedures or Methods:	Schedule of Evaluation:

Reporting on Progress:

☐ Option A - Progress Reporting (Graph) ☐ Option B - Progress Reporting (Text)

Student Name: **IEP Date:**

Programs and Services

Related Services with General Education and/or Special Education Programs
Direct Service: the primary mode of service is directly working with the student. There may be occasional consultation with others.
Consultative Service: the primary mode of service is working with the teacher(s) and others having daily contact with the student. Direct work with the student is occasional

Current IEP Year: From Date	**To Date:**
School Year: 2010-11	School Year: 2011-12
Grade:	Grade:

Related Services	Start Date (if different from IEP)	End Date (if different from IEP)	Service Mode	Minutes		Sessions		Frequency	Setting within Location
				Low Min.	High Min.	Low Number	High Number		
			☐ Direct ☐ Consultative	0	0	0	0		

Programs	Departmentalized	Start Date	End Date	LRE/FTE Calculation Area					Bldg/Location
				SE Setting		GE Setting		Total	
				Low Min/Wk	High Min/Wk	Low Min/Wk	High Min/Wk	Min/Wk	
	☐ Y ☐ N			0	0	0	0	0	
				SE FTE: 0		GE FTE: 0		Total FTE: 0	FTE as of 02/09/2011

Does the student require a reduced schedule? ☐ Yes ☐ No

Does the student receive Specialized Transportation? ☐ Yes ☐ No

Is there a need for placement with a teacher with an endorsement in a particular impairment category? ☐ Yes ☐ No

Is a Teacher Consultant with endorsement in the student's impairment needed to support the resource program teacher? ☐ Yes ☐ No

Extended School Year Services (ESY)

☐ **Extended School Year Services were considered.**

Recommendation:

☐ **The IEP Team determined that ESY services are not needed**

☐ **Based upon a review of data on one or more current annual goals, the IEP Team determined that ESY services are needed**

Student Name: IEP Date:

Assessment - Participation and Provisions

The Michigan state assessments are listed in the charts below by grade. If grade appropriate, the IEP team must indicate which assessments the student will take.

If IEP team determines that student must take MI-Access instead of a particular MEAP assessment, indicate why the student cannot participate in MEAP assessment; and why a particular MI-Access assessment (or alternate Social Studies Assessment) is appropriate.

The IEP Team has determined the following State and/or District Assessments will be administered:

Test	Subtest	Test Type	Timing/Scheduling	Setting	Presentation	Response
MEAP (Gr 3-9)						
MI-Access (Gr 3-8,11)						
ACT (Gr 11 -12)						
MME (Gr 11-12)						

Complete this if the student is age 14 or older. Required for Grade 11 High School ACT-MME:				
As appropriate, mark **ALL** school years for which the student has had an IEP or 504 Plan, including year(s) before high school:				
Below Grade 8 ☐	Grade 8 **School Year** (YY-YY)	Grade 9 **School Year** (YY-YY)	Grade 10 **School Year** (YY-YY)	Grade 11 **School Year** (YY-YY)

Student Name: **IEP Date:**

Other Considerations

Student Name: IEP Date:

Transition Activities/Services

Describe how the student's course of study aligns with the postsecondary vision:

Check Only One:

☐ Michigan Merit Curriculum leading to a high school diploma (beginning with class of 2011).
☐ Course of Study leading to:

Is . expected to graduate with a Regular Diploma during this IEP year? ☐ Yes ☐ No

Will . complete age eligibility for Special Education services? ☐ Yes ☐ No

Was there a need to invite a community agency representative likely to provide current or future services? ☐ Yes ☐ No
Please list any additional steps taken to ensure that the student has made connections with any appropriate outside programs and services:

Transition Consideration

Parental Rights and Age of Majority

Student's Post-Secondary Vision

Transition Assessments:

Has an Educational Development Plan been created? ☐ Yes ☐ No

Will a Student Transition Visions survey be completed? ☐ Yes ☐ No

If student did not attend IEP, describe steps taken to ensure consideration of student's preferences/vision:

Adult Living: As an adult, where do you want to live?

Community Participation: As an adult, what hobbies and activities do you want to do in your community? (arts, recreational activities, shopping, eating out, etc.)

Post Secondary Education/Training: After high school, what additional education and training do you want?

Transition Activities and Services - Required by Age 16

Needed Transition Activities/Services Related to Student's Postsecondary Vision and Present Level of Academic Achievement and Functional Performance:	Responsible Agency/Persons	Expected Completion Date
Is there a need for activities or services for the Instructional Area? ☐ Yes ☐ No		
Is there a need for activities or services in the area of Community Experiences? ☐ Yes ☐ No		
Is there a need for activities or services in the Development of Employment? ☐ Yes ☐ No		
Is there a need for Other Post-School Adult Living activities or services? ☐ Yes ☐ No		
When appropriate, is there a need for activities or services in the Acquisition of Daily Living Skills? ☐ Yes ☐ No		
When appropriate, is there a need for a Functional Vocational Evaluation? ☐ Yes ☐ No		

IEP Date:

Student Name: **IEP Completion Date:**

Commitment Signatures

Resident District - Resident District superintendent/designee (check all that apply):

____ Agrees with the IEP and its implementation

____ Disagrees with this IEP **and:** requests mediation. *(see bottom of page*)*

____ Authorizes the nonresident operating district to conduct subsequent IEP meetings.

____ Agrees that the student is not eligible for special education

Position responsible: Initial implementation site:

Signature: _____

(Resident District Superintendent or Designee)

Non-resident Operating District – The superintendent/designee:

____ Agrees to provide the IEP program(s) and/or service (s).

____ Disagrees with this IEP **and:** requests mediation.

____ Agrees to conduct subsequent IEP meetings.

____ Agrees that the student is not eligible for special education.

Position responsible: Initial implementation site:

Signature:

_____

(Operating District Superintendent or Designee)

Notice Requirements:

The superintendent or designee of the operating district ensures that:

a) to the maximum extent appropriate, a person who has a disability, including a person who is assigned to a public or private institution or other care facility, is educated with persons who do not have disabilities.

b) placement of a person who has a disability in special classes, separate schools, or the removal of a person who has a disability from the general education environment occurs only when the nature or severity of the disability is such that education in a regular class using supplementary aids and services cannot be satisfactorily achieved.

c) the placement for the student is as close as possible to his or her home.

d) unless the IEP of a student with a disability requires some other arrangement, the student is educated in the school that he or she would attend if non-disabled.

e) in selecting the least restrictive environment, consideration shall be given to any potentially harmful effects to the student or the quality of services that the student needs.

f) a student with a disability will not be removed from education in age-appropriate regular classrooms solely because of needed modifications in the general education curriculum.

Consent being provided by:

I have been informed of all procedural safeguards and sources to obtain assistance:

____ Understands the contents of this IEP.

____Disagrees, but will allow implementation of this IEP.

____Agrees with the IEP and its implementation.

____Disagrees with this IEP **and:** requests mediation.

____Agrees that the student is not eligible for special education.

_____ _____

Signature of Parent/Guardian Date

Student Signature - Optional for students under the Age of Majority (18)

_____ _____

Signature here shows student desires to work with this plan Date

Dissenting Opinion

Any IEP team member who disagrees with this IEP may attach a dissenting report.

Macomb Intermediate School District

Parent/Guardian/Adult Student Consent For Medicaid School Based Services Program

Student Name:	Date of Birth:	UIC:
IEP Meeting Date:		

The Medicaid School Based Services Program in Michigan provides partial reimbursement from Medicaid for services such as Occupational Therapy, Physical Therapy, Speech Therapy, Psychological Services, Social Work Services, Orientation and Mobility Services, Transportation, Nursing Services, Case Management and Assistive Technology Services.

Information about your child's school based services (which could include date of birth, disability, gender, school, date of therapy, type of therapy, and progress reports) is required by the Michigan Medicaid and billing agencies to obtain this reimbursement.

If your child receives any of the above services and qualifies for Medicaid benefits at any time during the school year, we request your permission for Macomb Intermediate School District and its local school districts to bill your child's Medicaid insurance to receive reimbursement.

You have the right to refuse consent to bill Medicaid, and you have the right to revoke this consent to bill Medicaid.

If you do not provide consent, the district will still provide the services but the district will not receive any Medicaid reimbursement for these services.

Your consent does NOT affect a family's Medicaid insurance benefits or other insurance plans (Blue Cross/Blue Shield, HAP, MiChild, etc.) and there is NO cost to the family, now or in the future.

I give permission for Macomb Intermediate School District and its local school districts to bill my child's Medicaid insurance for reimbursement of School Based Services provided during the school year as described in my child's IEP (Individualized Education Program) or IFSP (Individualized Family Service Plan).

☐ Consent obtained at meeting
☐ Consent was not obtained at the meeting

_____

Parent/Guardian/Adult Student Signature and Date