

## INDIVIDUALIZED EDUCATION PROGRAM

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

IEP Date: \_\_\_\_\_

Last Annual IEP \_\_\_\_\_ Next Annual IEP \_\_\_\_\_ Original Special Ed Entry Date \_\_\_\_\_

Last Eval \_\_\_\_\_ Next Eval \_\_\_\_\_

**Purpose of Meeting**  Initial  Annual  Triennial  Transition  Pre-Expulsion  Interim  
 Other

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender  Male  Female Grade \_\_\_\_\_ Migrant  Yes  NoNative Language \_\_\_\_\_ EL  Yes  No  Redesignated Interpreter  Yes  No

Student ID \_\_\_\_\_ SSN#: \_\_\_\_\_ ; \_\_\_\_\_ SSID# \_\_\_\_\_

**Residency** \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

District of Residence \_\_\_\_\_ Residence School \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Race 1. \_\_\_\_\_ Race 2. \_\_\_\_\_ Race 3. \_\_\_\_\_

**INDICATE DISABILITY/IES**

Note: For initial and triennial IEPs, assessment must be done and discussed by IEP Team before determining eligibility.

**Primary** \_\_\_\_\_ **Secondary** \_\_\_\_\_ \* 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 general curriculum(or for preschoolers, participation in appropriate activities)****For Initial Placements Only**

Has the student received IDEA Coordinated Early Intervening Services (CEIS) using 15% of IDEA funding in the past two years?

 Yes  No

Date of Initial Referral for Special Education Services \_\_\_\_\_

Person Initiating the Referral for Special Education service \_\_\_\_\_

Date District Received Parent Consent: \_\_\_\_\_

Date of Initial Meeting to Determine Eligibility \_\_\_\_\_

**PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE**

Name \_\_\_\_\_

IEP Date: \_\_\_\_\_

**Strengths/Preferences/Interests****Concerns of parent relevant to educational progress**

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**CA Standards Test****English/Language Arts** Adv.  Proficient  Basic  Below Basic  Far Below Basic**Math** Adv.  Proficient  Basic  Below Basic  Far Below Basic**Hist./Soc. Sciences** Adv.  Proficient  Basic  Below Basic  Far Below Basic**Science** Adv.  Proficient  Basic  Below Basic  Far Below Basic**CMA****English Language Arts****Mathematics** \_\_\_\_\_ **Science** \_\_\_\_\_ **Other** \_\_\_\_\_**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** ( \_\_\_\_\_ )  Pass  Fail  Other \_\_\_\_\_ **Vision** ( \_\_\_\_\_ )  Pass  Fail  Other \_\_\_\_\_

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**Precademic/Academic/Functional Skills****Communication Development****Gross/Fine Motor Development****Social Emotional/Behavioral****Vocational****Adaptive/Daily Living Skills****Health**

**STATE SELPA IEP TEMPLATE**

Name \_\_\_\_\_ IEP Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Does the student require assistive technology devices and/or services?  No  Yes - Specify \_\_\_\_\_

Does the student require low incidence services, equipment and/or materials to meet educational goals?  No  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?  No  Yes if yes, who will provide? \_\_\_\_\_
- Who will provide ELD instruction to student?  General Education  Special Education
- What type of ELD programs will be provided?  English Language Mainstream
- Structured English Immersion
- Alternative Program (native language instruction)

Comments \_\_\_\_\_

Does student's behavior impede learning of self or others?  No  Yes (describe) \_\_\_\_\_

If yes, specify positive behavior interventions, strategies, and supports \_\_\_\_\_

- Behavior Goal is part of this IEP
- Behavior Support Plan (BSP) attached
- Behavior Intervention Plan (BIP) attached

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

_____	_____
_____	_____
_____	_____
_____	_____

**Statewide Assessments**

Student: \_\_\_\_\_

**IEP Date:** \_\_\_\_\_**Participation in Statewide Assessment Program, STAR**

(California Standards Test, California Modified Assessment Test, California Alternate Performance Assessment)

**English Language Arts (ELA)** (Grades 2-11; CMA only applies to grades 3-11)

\_\_\_\_\_

**Math** (Grades 2-7 Grade level Math; Grades 8-9 General Math; Grades 8-11 Integrated Math1,2, or 3; Grades 9-11 Summative High School Math; Grades 3-7 CMA)

\_\_\_\_\_

**Algebra** (Grades 8-11; CMA Algebra 1 only) Test to be Administered:  Algebra 1  Algebra II (CST Only)

\_\_\_\_\_

**Geometry** (Grades 8-11)

\_\_\_\_\_

**Science** (Grades 5, 8 & 10 Science Test; Grades 9-11 Biology, Chemistry, Earth Science, Physics, and Integrated Science/ Coord Science 1,2,3 & 4)

\_\_\_\_\_

**History/Social Science** (Grades 8, 10 & 11)

\_\_\_\_\_

**Writing** (Grade 4 & 7 only)

\_\_\_\_\_

 If student is taking CMA or CAPA, IEP team has reviewed the criteria for taking alternate assessments.**CAPA ELA** (Grades 2-11) **Science** (Grades 5,8,10) **Math** (Grades 2-11) \_\_\_\_\_The student will not participate in the CST or CMA because  
Participating in the CAPA is appropriate because **Physical Fitness Test** (Grades 5, 7 & 9 only)  
Accommodations                      Modifications**CAHSEE** (Grades 10-12, or ages 15+ and grade code is 'Ungraded')

\_\_\_\_\_

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

Alternate Assessment(s) appropriate because:

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

Adaptations:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Not Applicable                        | <input type="checkbox"/> Sensory support                                  | <input type="checkbox"/> Functional positioning |
| <input type="checkbox"/> Alternative response mode             | <input type="checkbox"/> Assistive equipment or device                    | <input type="checkbox"/> Visual support         |
| <input type="checkbox"/> Alternative mode for written language | <input type="checkbox"/> Augmentative or alternative communication system |   |

**FOR ENGLISH LEARNERS ONLY** **CELDT**

- 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(s):  Listening  Speaking  Reading  Writing

Name of alternate assessment(s):

**Standards based Tests in Spanish STS**

- Math without testing accommodations
- Math with testing accommodations:
- Reading, Language, Spelling without accommodations
- Reading, Language, Spelling with accommodations:

## ANNUAL GOALS AND OBJECTIVES

Name \_\_\_\_\_

IEP Date: \_\_\_\_\_

<b>Area of Need:</b> _____  <b>Baseline:</b>	<b>Measurable Annual Goal#</b> _____  <input type="checkbox"/> Enables student to be involved/progress in general curriculum/state standard _____ <input type="checkbox"/> Addresses other educational needs resulting from the disability <input type="checkbox"/> Linguistically appropriate <input type="checkbox"/> Transition <b>Goal:</b> <input type="checkbox"/> Education/Training <input type="checkbox"/> Employment <input type="checkbox"/> Independent Living <b>Person(s) Responsible</b> _____
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Short-Term Objective:

Short-Term Objective:

Short-Term Objective:

**Progress Report 1:** \_\_\_\_\_  
**Summary of Progress**

Comment

**Progress Report 2:** \_\_\_\_\_  
**Summary of Progress**

Comment

**Progress Report 3:** \_\_\_\_\_  
**Summary of Progress**

Comment

**Goal: Annual Review**    **Date:** \_\_\_\_\_

**Goal Met**  Yes  No

**Comments:**

**DEMO SPECIAL EDUCATION LOCAL PLAN AREA (SELPA)  
ANNUAL GOALS AND BENCHMARKS**

Name \_\_\_\_\_

IEP Date: \_\_\_\_\_

<b>Area of Need:</b> _____  <b>Baseline:</b> _____	<b>Measurable Annual Goal#</b> _____  <input type="checkbox"/> Enables student to be involved/progress in general curriculum/state standard _____ <input type="checkbox"/> Addresses other educational needs resulting from the disability <input type="checkbox"/> Linguistically appropriate <input type="checkbox"/> Transition Goal: <input type="checkbox"/> Education/Training <input type="checkbox"/> Employment <input type="checkbox"/> Independent Living <b>Person(s) Responsible</b> _____
<b>Benchmark 1</b> Within _____, will achieve the above goal at _____	
<b>Benchmark 2</b> Within _____, will achieve the above goal at _____	
<b>Benchmark 3</b> Within _____, will achieve the above goal at _____	
<b>Progress Report 1:</b> _____ <b>Summary of Progress</b>  <b>Comment</b>	
<b>Progress Report 2:</b> _____ <b>Summary of Progress</b>  <b>Comment</b>	
<b>Progress Report 3:</b> _____ <b>Summary of Progress</b>  <b>Comment</b>	
<b>Goal: Annual Review</b> <b>Date:</b> _____ <b>Goal Met</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Comments:</b>	

**Offer of FAPE  
SERVICES**

Name \_\_\_\_\_

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
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Transportation Special Ed  No  Yes

**SPECIAL EDUCATION and RELATED SERVICES**

<b>Service:</b> _____
<b>Start Date:</b> _____ <b>End Date:</b> _____
<b>Provider:</b> _____ <input type="checkbox"/> Ind <input type="checkbox"/> Grp <input type="checkbox"/> Sec Transition
<b>Duration/Freq:</b> _____ min _____ <b>Totaling:</b> _____ min served _____
<b>Location:</b> _____
<b>Comments:</b> _____
<b>Service:</b> _____
<b>Start Date:</b> _____ <b>End Date:</b> _____
<b>Provider:</b> _____ <input type="checkbox"/> Ind <input type="checkbox"/> Grp <input type="checkbox"/> Sec Transition
<b>Duration/Freq:</b> _____ min _____ <b>Totaling:</b> _____ min served _____
<b>Location:</b> _____
<b>Comments:</b> _____

**EXTENDED SCHOOL YEAR (ESY)**

Yes  No

<b>Service:</b> _____
<b>Start Date:</b> _____ <b>End Date:</b> _____
<b>Provider:</b> _____ <input type="checkbox"/> Ind <input type="checkbox"/> Grp <input type="checkbox"/> Sec Transition
<b>Duration/Freq:</b> _____ min _____ <b>Totaling:</b> _____ min served _____
<b>Location:</b> _____
<b>Comments:</b> _____

Programs and services will be provided according to when 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.



**Offer of FAPE  
EDUCATIONAL SETTING**

Name \_\_\_\_\_

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 & extracurricular & non academic activities \_\_\_\_\_  
because

Other Agency Services

California Children's Services(CCS)

Regional Center

Probation

Department of Rehabilitation

Dept. of Social Services(DSS)

Other \_\_\_\_\_

County Mental Health (CMH)

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, 8th-9th grade, etc)

**GRADUATION PLAN**  
(Grade 7 and Higher)

Projected graduation date and/or secondary completion date \_\_\_\_\_

\_\_\_\_\_

## SIGNATURE AND PARENT CONSENT

Name \_\_\_\_\_

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\_\_\_\_\_  
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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 not eligible for special education. I understand that my child is no longer 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: \_\_\_\_\_

Date \_\_\_\_\_

 Parent  Guardian  Surrogate  Adult Student

Signature: \_\_\_\_\_

Date \_\_\_\_\_

 Parent  Guardian  Surrogate  Adult StudentIf my child is or may become eligible for public benefits (Medi-Cal): I authorize the district to access Medi-Cal: health insurance benefits for applicable services.  Yes  No\_\_\_\_\_  
Parent/Guardian Signature

- Parent has received a copy of the Procedural Safeguards  Parent has received a copy of assessment report (if applicable)
- Parent has received a copy of the Individualized Education Plan (IEP)
- Parent 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.

IEP TEAM MEETING NOTES

Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ IEP Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Comments \_\_\_\_\_

Lined area for writing comments, consisting of multiple horizontal lines.