FORMS

1. **Individualized Family Service Plan (IFSP)**
2. **Individualized Education Program (IEP)**

Individualized Family Service Plan

*Indicates information to be entered and stored electronically at the System Point of Entry

Section 1 Child Information

*Child's name: (Last/First/MI)	*Nickname:	*Gender: Circle one M or F
*Home address:	*Mailing address:	
*City/Town:	*Zip Code:	*Parish of Residence:
*Date of Birth:	*Current Age/Adjusted Age:	Today's date:

Child's Medicaid Number (if applicable): _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ ICD-9 Code:_____

Section 1 A. General Contact Information

*Parent/Guardian:

*Relationship to child:

Telephone: Home: _____
Work: _____ Cell: _____
Other phone contact: _____
Best Time to Call: _____ Email: _____

Other Contact:	Telephone
Name:	Home:
Relationship:	Work:
	Cell

Additional contact information:

Section 1 B. IFSP History & Family Support Coordinator

*Name of FSC:

Telephone:

IFSP History

*Date of Initial IFSP	Projected Date of Annual IFSP

***Type of IFSP and Date**

☐ Interim	☐ 6 month Review
☐ Initial	☐ Transition
☐ Annual	☐ Review/Revision

Notes:

IFSP Documentation List:
Section 1: Child-Family Demographics
Section 2: Family Concerns Priorities and Resources
This section taken from page 8 of Family Assessment
Section 3a: Health History Form, page 2
Health Summary Updated: _____Yes _____No
Section 3b: Present Levels of Development and BDI-2 Evaluation Report Form (page 3)
Section 4: IFSP Outcomes
Section 5: Transition Outcomes
Section 6: EI Services
Section 7a: Assistive Technology
Section 7b: Transportation
Section 8: Other Services
Section 9: Team Participants
Section 10: Services outside Natural Environment Justification

IFSP 6 Month Review/Revision Section
IFSP page 1,
IFSP section 4 (if outcome added/revised)
IFSP section 5
IFSP Section 6 (updated, revised, or new if necessary)
IFSP Section 9
If outcome is added, additional outcome page(s) must be completed:

Indicate Concern and Rationale for Change:

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 2: Summary of Family Concerns, Priorities, and Resources to enhance the development of their child

This page is taken from page 8 of Family Assessment form and inserted in Section 2 of the IFSP **(Additional pages may be used if necessary)**

Date Completed: _____

Check appropriate box: ☐ Family assessment completed with family concurrence

☐ Family declined family assessment of concerns, priorities and resources (Parent signature)_____

Priority	Domain	Resource
☐	☐Physical ☐ Cognition ☐Communication ☐Adaptive ☐Social or Emotional ☐Other	
☐	☐Physical ☐ Cognition ☐Communication ☐Adaptive ☐Social or Emotional ☐Other	
☐	☐Physical ☐ Cognition ☐Communication ☐Adaptive ☐Social or Emotional ☐Other	
☐	☐Physical ☐ Cognition ☐Communication ☐Adaptive ☐Social or Emotional ☐Other	
☐	☐Physical ☐ Cognition ☐Communication ☐Adaptive ☐Social or Emotional ☐Othere	
☐	☐Physical ☐ Cognition ☐Communication ☐Adaptive ☐Social or Emotional ☐Other	

Child Name:_____ Date Completed:_____

Section 3a: Present Levels of Health Functioning

Health History Form, page 2 **This page inserted as Section 3a of the IFSP**

Hearing Status:

Last Hearing Test Date:_____ Results:_____
Newborn Hearing Screen Results: ☐ Pass ☐ Fail ☐ Follow up: _____date
Hearing Aids: ☐ Yes ☐ No Ear Infections: ☐ Yes ☐ No Tubes: ☐ Yes ☐ No
Parent Concerns:_____
Risk factors from page 1 of Health History checked: ☐ Yes ☐ No

Hearing Screen Current within 3 months: ☐ **Yes** ☐ No
If no, Hearing Screen to be scheduled: ☐ **Yes** ☐ No

Vision Status:

Last Vision Test Date:_____ Results:_____
Glasses : ☐ Yes ☐ No
Parent Concerns:_____
Risk factors from page 1 of Health History checked: ☐ Yes ☐ No

Vision Screen Current within 3 months: ☐ **Yes** ☐ No
If no, Vision Screen to be scheduled: ☐ **Yes** ☐ No

Birth History and Physical Development/Health Status

Complete at Initial IFSP ONLY: Was your child's birth premature**?** ☐ No ☐ Yes How many weeks early was your child born?_____
Gestational age? _____ Birth weight? _____Birth Length**:**_____ Hospital Stay after Birth**:**_____

Update remaining section annually: Current Weight**:**_____
What medical diagnoses does your child have that you are aware of?_____
ICD – 9 Code:_____

Nutrition Status:

Diet: Bottle/Breast Feeding: ☐ Yes ☐ No **Formula/Oz/Day:**_____ **Special diet?** ☐ No ☐ Yes _____
WIC? ☐ Yes ☐ No Referral Needed: ☐ Yes ☐ No
Known allergies: ☐ Yes ☐ No If yes, specify type:_____
Other Health Information to Assist in Planning:_____

Adaptive Equipment	**Medical Equipment**
☐ Wheelchair ☐ Splints/AFOs/Braces ☐ Adaptive Seating ☐ Adaptive Bathing ☐ Feeding Aids ☐ Other: _____ ☐ No adaptive equipment	Special Equipment child came home from hospital with: **Hospital Discharge:** **Current**: ☐ Apnea monitor ☐ Apnea monitor ☐ Oxygen ☐ Oxygen ☐ Feeding tube ☐ Feeding tube ☐ Ventilator ☐ Ventilator ☐ Trach ☐ Trach ☐ Nebulizer ☐ Nebulizer ☐ Other: _____ ☐ Other: _____ ☐ No medical equipment ☐ No medical equipment

Does your child receive any medications? (List type and purpose)

Medication:	**Purpose:**

Section 3b: IFSP Present Levels of Development and BDI-2 Evaluation Report

Page 3 of the BDI-2 Evaluation Report & IFSP and Program Planning Report

Child's Name: _____ DOB: _____ Chronological Age: _____

□ **Initial Eligibility** □ **Annual Eligibility** □ **Revision**

Give brief summary of development in each domain from BDI-2 or other assessment(s).

Domain	BDI-2 Scores	Other Assessment Results /Current Developmental Status
Adaptive	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Social-Emotional	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Communication	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Receptive	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Expressive	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Physical	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Gross Motor	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Fine Motor	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	
Cognition	Sum of Scaled Score: _____ DQ Score: _____ SD Score: +____ above the mean -_____below the mean _____at the mean	

* Attach Original Assessment scoring booklet * Form to be completed at initial evaluation, annual evaluation, and exit evaluation. Vision and Hearing status in Health History

_____ _____ _____

Provider Signature & Credentials Provider Phone Number Date of Assessment

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Type of IFSP: □ Initial □ Review/Revision: □ New □ Revise □ Completed Outcome □ Annual

Section 4: Outcomes for child and family Complete a separate page for each outcome including at least one for FSC

Outcome Number ____: Description:	What's happening now?	Our team will be satisfied that we are finished with this outcome when (criteria for measuring progress):

What skills and behaviors do we want this child and family to accomplish in the next 3-6 months?

In 3 months:_____

_____

In 6 months:_____

_____

This outcome will include these strategies we will use to enhance this child's pre-literacy and language skills:

- ☐ Birth to three months – visual tracking, smiling and responding to social interaction
- ☐ Three to six months – responding to tones in voices, attending to others speaking
- ☐ Six to twelve months – babbling and imitating sounds
- ☐ Twelve to eighteen months – look at point to pictures in books, participate in songs with hand motions
- ☐ Eighteen to twenty four months - naming pictures in books and listening to stories
- ☐ Twenty four to thirty six months – singing songs, nursery rhymes, filling in words to familiar stories
- ☐ Other: _____

What strategies will the family/other caregivers use in their daily routines and activities to achieve the outcome?

☐ verbal prompting/ instructing	☐ with adaptive equipment ☐ with environmental modifications
☐ modeling (with verbal prompting)	**Strategies for Support Coordination Outcome**
☐ gesturing (with verbal prompting)	☐ Monthly telephone calls with family
☐ physically assisting/supporting/guiding (with verbal prompting)	☐ Communication with other service providers ☐ Other: _____
☐ Counseling for family	☐ Link family with community resources and monitor progress
☐ Classes/groups to attend	☐ Assist family with referral and application for services (IFSP Section 8 Other Services)
☐ Other	☐ Team Meetings (minimum quarterly)
With whom will these strategies be practiced? ☐ family members ☐ relatives ☐ child care staff ☐ service provider(s):_____ ☐ Service Coordinator **(if checked complete strategies for FSC outcome)** ☐ other:_____	Where can these strategies be practiced? ☐ special purpose facility ☐ special purpose facility with inclusive childcare ☐ community setting ☐ other:_____ ☐ home
We will measure progress towards the achievement of this outcome by: ☐ observation ☐ case notes/progress reports ☐ assessment/evaluation by team ☐ quarterly team meetings ☐ telephone calls ☐Other:_____ ☐ parent observation and report	Daily living routine addressed by this outcome: ☐ bathing ☐ dressing ☐ eating ☐ potty training ☐ playing indoors ☐ playing outdoors ☐ sleeping/napping ☐ other:_____

IFSP Review/Revision: □ Add outcome(add page) □ Change Outcome □ Revise Strategies □ No Changes in outcomes

Services: □Add □Drop □Frequency/Intensity Change □Change location □Change Provider (Supplement with Team Decision Process)

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 5: Transition Planning: Early Transition and Transition at Age Three

A. Plan for Transition **Must be discussed at each IFSP meeting.**		**Sign/Initial**	**Date of Discussion**
Procedures we will use to prepare the child for the upcoming transition: Procedures to prepare the child/family for changes in service delivery: _____ ☐ Discussed with parents future placements and other matters related to the child's transition. ☐ Discussed with parents community programs available following transition from Part C.	Program options identified by the team (check all that apply): ☐ Part B ☐ Head Start/ Early Head Start ☐ Child Care ☐ Other community resources ☐ OCDD/HSA/D ☐ Medicaid EPSDT services ☐ Other: _____	A plan for transition at Age 3 has been discussed: ☐ FSC: _____ ☐ Parent: _____	___/___/___

B. Early Transition Event and Issue *Check the appropriate box, if applicable*	**Early Transition Steps**	**Sign/Initial**	**Date of Discussion**
☐ Child is coming home from hospital; need to ensure no disruption of necessary services ☐ Family will be experiencing a change that may affect the delivery of an IFSP service (birth or adoption of sibling, medical needs of other family members, employment or loss of employment) ☐ Child will be experiencing a change that may affect the delivery of an IFSP service (i.e., hospitalization, placement in child care setting, medication changes, etc) ☐ Changes in IFSP services (i.e., termination/addition of service, change in location of service) ☐ Early Exit Before Age Three: Child is exiting EarlySteps, no longer eligible, parent declines participation in EarlySteps ☐ Plan for disposition of Assistive Device, if applicable: If box is checked above develop steps for transition in next column ☐ Schedule BDI-2 Exit; Date BDI-2 Requested:_____/_____/_____	☐ Early Transition Steps: ☐ Referral for Medicaid EPSDT services ☐ Assistance with referral to other community Resources: _____ ☐ Assistance with referral for Part C Services in other states: _____ ☐ SPOE to SPOE transfer in Louisiana ☐ Other: _____ ☐ Early Exit Steps ☐ Referral for Medicaid EPSDT case management ☐ Discuss OCDD/HSA/D entry requirements at age three with family ☐ Other: _____ ☐ Changes in Service Delivery Steps: ☐ Meet service providers ☐ Visit community service agencies ☐ Review written materials ☐ Other: _____	Early transition events and issues have been discussed: ☐ FSC: _____ ☐ Parent: _____	1. ___/___/___ 2. ___/___/___

C. Transition Conference at Age Three		
☐ Transition Notification Letter Sent to LEA at 2 years 2 months: _____ ☐ Child specific records were sent to the LEA ☐ Parent did not consent to record release : _____ (parent's initials) ☐ LEA was notified of child's upcoming transition conference: _____ ☐ Parent declined LEA attendance at transition conference: _____ (parent's initials) ☐ Schedule BDI-2 Exit; Date DBI-2 Exit Requested:_____/_____/_____	**Age three transition steps and services:** ☐ Family attends transition workshop ☐ Family and child visit LEA preschool sites ☐ Family and child visit /get information on Head Start centers ☐ Family visits other community agencies: preschool, child care, etc. ☐ Family contacts OCDD/HSA/D for entry ☐ LEA to schedule eligibility evaluation ☐ FSC to attend initial IEP meeting: ___/___/___ ☐ Part C Services End: ___/___/___ Discuss Program Options for remainder of school year ☐ Talk to other families ☐ Other: _____	Date of Transition Conference: ____/____/____

This child requires a referral for OCDD eligibility determination ☐ yes ☐ no If yes, date referral packet sent: _____/_____/_____

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 6: Early Intervention Services

*This entire page is part of the electronic record. **Attach Section 7A/B if Assistive Technology and/or Transportation are necessary to achieve the IFSP outcomes. Use codes as listed here for completion.**

Modification	Column A Early Intervention Service	B Outcome Number	C Location	D Frequency	E Intensity	F Start Date	G End Date	H Method	I Funding Source	J Provider's Name/Payee Type (including name of agency)
	Family Service Coordinator									☐ Independent ☐ Agency ☐ No Provider Available Name:
	Service: _____ ☐ Individual ☐ Group									☐ Independent ☐ Agency ☐ No Provider Available Name: Assistant Name(if applicable):
	Service: ____ ☐ Individual ☐ Group									☐ Independent ☐ Agency ☐ No Provider Available Name: Assistant Name(if applicable):
	Service: _____ ☐ Individual ☐ Group									☐ Independent ☐ Agency ☐ No Provider Available Name: Assistant Name(if applicable):
	Service: _____ ☐ Individual ☐ Group									☐ Independent ☐ Agency ☐ No Provider Available Name: Assistant Name(if applicable):

Services: □Add(+) □Frequency/Intensity Change □Change location □Change Provider (Supplement with Team Decision Process) □No Change (NC) □Drop (-) Service: _____ Date: _____

Section K: Primary Setting: What is the setting where the majority of services will be provided? Choose one from list below.

☐ Home ☐ Community Setting ☐ Special Purpose Center ☐ Hospital ☐ Residential Facility ☐ Service Provider Setting ☐ Other Setting

****LEGEND**

Column C - Location	Column H - Method	Column I - Funding
1= Home/community setting	1 =Early intervention service	A = Part C/State Funding
5=Special purpose center w/inclusive childcare	2= Family education/training	B = Medicaid C = MFP
6=Special purpose center or clinic	3=Assessment	

Parent Consent for Services: The contents of this IFSP have been fully explained to me. I give informed, written consent to implement the services described in Section 7 of the IFSP. I have received a written copy of our Parent's Rights in EarlySteps. **I understand that EarlySteps must wait at least 3 calendar days before taking any action.** I understand that I can revoke the consent for any service at any time.

_____
Parent Signature Date

Initial IFSP Date:_____ Type of IFSP: ☐ Initial ☐ Review/Revision _____ ☐ Annual _____

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 7A. Complete this page as needed

Assistive Technology Device

Child's Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ __

IFSP Outcome Number	*Name of Device	*Vendor Providing Device	Where is device used?	When is device used? *indicate activities	*Start date for device use	*End date for device use	*HCPCs Code	*Price/Cost
	Is this covered by Medicaid? Yes No Did Medicaid provide? Yes No If no - attach copy of Medicaid denial letter.		☐ Home ☐ Child care ☐ Relative's home ☐ Community setting: _____ ☐ Other:					
	Is this covered by Medicaid? Yes No Did Medicaid provide? Yes No If no - attach copy of Medicaid denial letter.		☐ Home ☐ Child care ☐ Relative's home ☐ Community setting: _____ ☐ Other:					
Approval required for any item costing over $500.00 or if total of all items is more than $500.00							Total cost for all AT Devices listed: $	

I understand that any equipment provided by EarlySteps over $500.00 is the property of the state of Louisiana and I may be required to return this equipment upon my child's exit from EarlySteps.

Parent Signature: _____

Section 7B: Transportation Necessary to access Early Intervention Services

IFSP Outcome Number	*Start Date	*End Date	*Provider (Parent Name)	*Frequency	*Maximum miles per trip expressed as round trip

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 8: Other Services Needed to Enhance Child's Development

Service	Family or Child Service (circle)	Responsible Person Contact Information	Funding Source or Steps to secure service
Primary Medical Home or Physician	Child		
	Child Family		
	Child Family		
	Child Family		
	Child Family		

Section 9: IFSP Team

Printed Name	Position/Role	Agency (if applicable)	Telephone Number	Signature or Method of Participation
	Parent			Signature:
	IC (only at initial IFSP)			Signature:
	EIC (required for informed clinical opinion)			Signature:
	FSC			Signature:
	CDA Provider			☐ Telephone ☐ Report Signature:
	Provider			☐ Telephone ☐ Report Signature:
				☐ Telephone ☐ Report Signature:
				☐ Telephone ☐ Report Signature:
				☐ Telephone ☐ Report Signature:

Child's Name: _____ Last/First/MI	Date of Birth: _____ Mm/dd/yyyy	Date of IFSP: _____ Mm/dd/yyyy

Section 10: Justification for Early Intervention Services Delivered Outside of the Natural Environment

Complete and attach to the IFSP only as required.

Early Intervention Service Not Provided in Natural Environment	Child specific reason why early intervention can not be satisfactorily achieved in a natural environment: Data to support this team decision:	How will services be incorporated into the Natural Environment? ☐ Provider will send a note home after each session for the family ☐ Provider will talk with the parent every 2 weeks regarding the child's progress ☐ Provider will send home information on the strategies the child is learning, so the parent can incorporate these strategies into the child's routine at home ☐ The parent will call the provider if he/she is unclear on how to implement a new strategy ☐ Parent or caregiver will participate in sessions when possible ☐ Other: _____
Early Intervention Service Not Provided in Natural Environment	Child specific reason why early intervention can not be satisfactorily achieved in a natural environment: Data to support this team decision:	How will services be incorporated into the Natural Environment? ☐ Provider will send a note home after each session for the family ☐ Provider will talk with the parent 2 weeks regarding the child's progress ☐ Provider will send home information on the strategies the child is learning, so the parent can incorporate these strategies into the child's routine at home ☐ The parent will call the provider if he/she is unclear on how to implement a new strategy ☐ Parent or caregiver will participate in sessions when possible ☐ Other: _____
Early Intervention Service Not Provided in Natural Environment	Child specific reason why early intervention can not be satisfactorily achieved in a natural environment: Data to support this team decision:	How will services be incorporated into the Natural Environment? ☐ Provider will send a note home after each session for the family ☐ Provider will talk with the parent 2 weeks regarding the child's progress ☐ Provider will send home information on the strategies the child is learning, so the parent can incorporate these strategies into the child's routine at home ☐ The parent will call the provider if he/she is unclear on how to implement a new strategy ☐ Parent or caregiver will participate in sessions when possible ☐ Other: _____

Initial IFSP Date:_____ Type of IFSP: ☐ Initial _____ ☐ Review/Revision _____ ☐ Annual _____

Transition Services

Date of Student Invitation: | Method of Student Invitation:

Measurable Postsecondary Goals (Outcomes that occur after the student has left high school.)

Training or Education Goal:
Employment Goal:
Independent Living Goal: (if applicable)

Transition Assessments List the multiple assessments used to address the student's career interests, vocational skills, employability, independent living skills, self advocacy and other preferences and interests. Assessment documentation must be included in IEP folder.

TRANSITION SERVICES	SCHOOL ACTION STEPS	STUDENT ACTION STEPS	FAMILY ACTION STEPS	AGENCY ACTION STEPS
INSTRUCTION/ RELATED SERVICES				
COMMUNITY EXPERIENCES				
EMPLOYMENT AND POSTSCHOOL ADULT LIVING				
FUNCTIONAL VOCATIONAL EVALUATION AND DAILY LIVING SKILLS				

WHEN NEEDED, IF A PARTICIPATING AGENCY DOES NOT ATTEND, DOCUMENT OTHER ACTIONS FOR AGENCY LINKAGES.

Exit Document: _____
Years to Graduate: _____
Anticipated Exit Date: _____

General Student Information

HOMEBASED SCHOOL: _____ OTHER SCHOOL: _____

IEP TYPE: _____ INDIVIDUAL EVALUATION / WAIVER DATE: _____

Primary / Other	Exceptionality	Detail(s)
Primary		
Other		
Other		
Other		
Other		

IEP Participants	Name	IEP Participants	Name

Include strengths; parental concerns; evaluation results; academic, developmental, and functional needs; statewide assessment results; progress or lack of expected progress in general education curriculum; and consideration of special factors: behavior, language needs for limited English proficient, instruction in and use of braille, communication needs, assistive technology devices and services, and health needs.

General Information about the Student:	
Strengths:	
Parent Concerns:	
Evaluation / Reevaluation Results:	
Academic, Developmental, and Functional Needs:	
Statewide Assessment Results:	
Progress or lack of expected progress in general education curriculum:	

General Student Information (continued)

Consideration of Special Factors

Behavior:	
Limited English Proficent:	
Communication Needs of Child:	
Instruction in and use of Braille:	
Assistive Technology Services / Devices - Please indicate AT devices used on the Accommodations Page	
Health needs - IHP needs to be attached to IEP	

☐ **After consideration by the IEP team, there are no special factors that need to be addressed at this time**

Transition Courses of Study - Attach plan to IEP: ☐ Individual Prescription for Instruction ☐ Individual Graduation Plan ☐ Educational / Career Plan for LAA1 Students

Educational Needs: ☐ Academic/Cognitive ☐ Behavior ☐ Communication ☐ Motor ☐ Self-Help ☐ Social

Accommodations

CHECK THE INDIVIDUAL ACCOMMODATIONS NEEDED

☐ **ESY Instruction**

ENVIRONMENT

☐ Assign preferential seating
☐ **Provide individual instruction**
☐ **Provide small group instruction**
☐ Assign peer tutors/work buddies/note takers
☐ Provide desktop list of tasks
☐ Alter physical room environment
☐ Modify student's schedule (describe)
☐ Other (specify)

INSTRUCTION/MATERIALS

☐ Modify assignments as needed (e.g., vary length, limit items)
☐ **Utilize oral responses to assignments/tests (answers recorded)**
☐ **Read class materials orally**
☐ Provide study outlines/guides
☐ Provide daily assignment list
☐ Provide homework lists
☐ Provide assistance/cues for transitions between activities
☐ Provide options for students to obtain information and demonstrate knowledge through use of ☐ alternative projects ☐ interviews ☐ oral reports
☐ Shorten assignments
☐ Modify/repeat/model directions
☐ Utilize multi-sensory modes to reinforce instruction
☐ **Transferred answers**
☐ Use text/workbooks/worksheets at a modified reading level
☐ Alter format of materials on page (type/highlight/spacing)
☐ **Utilize large print**
☐ **Utilize braille**
☐ Utilize audio/recorded books
☐ Utilize digital formats
☐ Other Instruction (specify)
☐ Utilize graphic/pictorial mode materials
☐ Utilize print with magnification
☐ Color code materials
☐ Other Materials (specify)

☐ **COMMUNICATION ASSISTANCE - related to hearing loss only (describe)**

TIME

☐ **Increase the amount of time allowed to complete assignments and tests**
☐ Limit amount of work required or length of tests
☐ **Allow breaks during work periods, between tasks, during testing**
☐ Provide assistance/cues for transitions betwen classes, lockers, and home
☐ Other (specify)

TESTS/QUIZZES/PROJECTS

☐ Prior notice of tests
☐ Limited multiple choice
☐ **Extra time – tests**
☐ Pace long term projects
☐ Preview test procedures
☐ Student writes on test
☐ Objective tests
☐ Extra time – projects
☐ Rephrase test questions/directions
☐ Test study guide
☐ Shortened tasks
☐ Modified tests (describe)
☐ Other (specify)
☐ Extra credit options
☐ Extra response time
☐ Simplify test wording
☐ Hands-on-projects
☐ **Extra time-written work**
☐ **Tests Read Aloud**
☐ **Individual testing**
☐ **Small group testing**
☐ **Transferred answers**
☐ **Answers recorded**

☐ **ASSISTIVE TECHNOLOGY**

☐ **Digital Recorders**
☐ Manipulatives
☐ Text-to-speech
☐ Colored reading filters
☐ Eye gaze communication system
☐ Adapted grips/utensils/pencils/drawing tools
☐ Other AT devices (specify)
☐ **Calculators**
☐ Organizers
☐ FM system
☐ **Word Processors**
☐ Adapted toys/games
☐ Communication board/system
☐ Voice output device
☐ Voice recognition software

☐ **NONE**

The accommodations bolded on this page match the LEAP test accommodations on the program/services page of the IEP.

Program / Services

LOUISIANA EDUCATIONAL ASSESSMENT PROGRAM

LEAP/iLEAP/GEE/EOC ☐

Alternate Assessment ☐ LAA 1 ☐ LAA 2 ☐ ELA ☐ Math ☐ Science ☐ Social Studies

Academic Skills Assessment (non-diploma exit pathway) ☐ ASA ☐ ASA LAA 2

None ☐

1) If alternate assessment is checked, explain why the student cannot participate in the regular assessment, and

2) why the particular alternate assessment selected is appropriate for student

ACCOMMODATION(S) NEEDED FOR STATEWIDE ASSESSMENT (CHECK ALL THAT APPLY.)

- ☐ **None**
- ☐ Answers Recorded
- ☐ Large Print
- ☐ Braille
- ☐ Individual
- ☐ Tests Read Aloud except Reading Comprehension*
- ☐ Transferred answers
- ☐ Extended Time
- ☐ Communication Assistance
- ☐ Small Group

☐ Assistive Technology: Identify the type of AT to be used

☐ Other

REGULAR CLASSES

- ☐ Reading
- ☐ Science
- ☐ Math
- ☐ Vocational
- ☐ Electives (list)
- ☐ Spelling
- ☐ Writing
- ☐ Art/Music
- ☐ English/Language Arts
- ☐ Physical Education
- ☐ Social Studies
- ☐ Foreign Language

If not in regular classes, explain

ACTIVITIES WITH NON-DISABLED PEERS (Check all activities with non-disabled peers)

- ☐ Assemblies
- ☐ Library
- ☐ Extracurricular/Nonacademic
- ☐ Other
- ☐ Buses
- ☐ Meals
- ☐ Field Trips
- ☐ Recess

☐ If not participating in activities with non-disabled peers,explain

EXTENDED SCHOOL YEAR SERVICES (ESYS)

Criteria For Consideration:

- ☐ Regression / Recoupment
- ☐ Critical Point of Instruction 1
- ☐ Critical Point of Instruction 2

Special Circumstances

- ☐ Employment
- ☐ Transition to Part B (Preschool)
- ☐ Transition to Post School Outcomes
- ☐ Excessive Absences
- ☐ Extenuating Circumstances

Supports Needed for School Personnel (Describe)

Services / Placement

STUDENTS TOTAL INSTRUCTIONAL DAY (Minutes): _____ Student attends school ☐ days per week.

			Individual /	Regular Class		Community		Special Class	
Service	Date to Begin	Duration	Group	Minutes	Sessions	Minutes	Sessions	Minutes	Sessions

Total Number of Minutes in Special Setting per Week: _____

PLACEMENT/SERVICE DETERMINATION CHECKLIST

Attends Regular Early Childhood Program at least 10 hours per week
- ☐ Receives majority of hours of special education and related services in the regular early childhood program
- ☐ Receives majority of hours of special education and related services in some other location

Attends Regular Early Childhood Program less than 10 hours per week
- ☐ Receives majority of hours of special education and related services in the regular early childhood program
- ☐ Receives majority of hours of special education and related services in some other location

Attends Special Education Program (not in any regular early childhood program)
- ☐ Separate Special Education Class ☐ Residential Facility
- ☐ Separate School

Attends neither a regular early childhood program nor a special education program
- ☐ Receives majority of special education and related services at home
- ☐ Receives majority of special education and related services at service provider or other location

COMMENTS

Placement

Special Transportation

☐ No ☐ Yes - Describe

SITE DETERMINATION

NOTE: The local education agency may choose to complete this section at this time. If the following assurances cannot be provided at this time, then a Site Determination Form assuring that the site selected is in accordance with least restrictive environment rules must be forwarded to the parent within ten (10) calendar days.

ASSURANCES:

1. This school is the one the student would attend if he or she were not identified exceptional.
2. This school and class are chronologically age appropriate for the student.
3. The school selected is accessible to the student for all school activities.
4. The classroom is comparable to and integrated with regular classes.

Site: Lafayette Parish-Charles M. Burke Elementary School (028047)

PROGRESS REPORT

The LEA assures that the program and services described in the IEP will be provided. The schedule for describing the progress towards achievement of the academic and functional annual goals will be every ☐ weeks, current with the issuance of report cards.

ASSESSMENT IMPLICATIONS (Check one)

☐ I understand my child (I) will participate in LEAP Alternate Assessment, Level 1 (LAA 1). Testing in LAA 1 means my child (I) will be progressing toward a Certificate of Achievement and not a High School Diploma. The implications of participating in LAA 1 have been explained to me and will be reviewed annually.

☐ I understand my child (I) will participate in LEAP Alternate Assessment, Level 2 (LAA 2), and by meeting all graduation requirements, my child (I) will receive a High School Diploma. However, if during my child's (my) exit year all graduation requirements have not been met, then my child (I) may be eligible to exit high school with a Certificate of Achievement. I understand that this certificate limits my child's (my) choices of post-secondary education and careers, including military services. The implications of participating in LAA 2 have been explained to me and will be reviewed annually.

☐ I understand my child (I) will be participating in the Academic Skills Assessment (ASA) or ASA LAA 2, if eligible. My child (I) is (am) leaving the high school diploma pathway and is (am) entering a non-diploma pathway. If successful, my child (I) will receive a Louisiana Equivalency Diploma (GED) with possibly an Industry-Based Certificate, or a State-Approved Skills Certificate but not a High School Diploma. The implications of participating in ASA or ASA LAA 2 have been explained to me and will be reviewed annually.

AGE OF MAJORITY

☐ **Beginning at least one year before reaching the age of majority, I (my child) have been informed that my (his or her) rights under the act will transfer to me (my child) on my (his or her) reaching the age of majority**

PARENT/STUDENT* CONSENT FOR SERVICES

☐ I have received a copy of the Educational Rights of Exceptional Children, and was given an opportunity for an oral explanation. I have received a copy of my (child's) evaluation and documentation of determination of eligibility.

☐ I give consent for the provision of special education and related services. I understand that if I disagree with any services or the placement described on the IEP, I can pursue a solution to my complaint through the state's written dispute resolution options.

☐ Parent / Student did not attend the **Review** IEP Team meeting.

SUPPORTING DOCUMENTATION

Have the following documents been included in the IEP folder?

LEAP Alternate Assessment Participation Criteria, Level 1 (LAA 1)	☐ Yes	☐ N/A
LEAP Alternate Assessment Participation Criteria, Level 2 (LAA 2)	☐ Yes	☐ N/A
Individual Healthcare Plan	☐ Yes	☐ N/A
Individual Prescription for Instruction (get copy from advisor/school guidance counselor)	☐ Yes	☐ N/A
Individual Graduation Plan (get copy from school guidance counselor)	☐ Yes	☐ N/A
Parental Consent form for Connections for 8th graders (get signed copy from SBLC team)	☐ Yes	☐ N/A
Summary of Performance Criteria Form	☐ Yes	☐ N/A
Parental Consent form for Medicaid Billing	☐ Yes	☐ N/A
Educational / Career Plan for LAA 1 Students	☐ Yes	☐ N/A
Behavior Intervention Plan	☐ Yes	☐ N/A
Assistive Technology Consideration Checklist	☐ Yes	☐ N/A

SIGN: _____

PARENT/GUARDIAN/SURROGATE PARENT/COMPETENT MAJOR/STUDENT **Date**

PRINT:

*Signature is only required for the **initial** provision of services.
*Parents should initial and date in signature box if they attended an IEP team meeting where the IEP was amended.

SIGN: _____

OFFICIALLY DESIGNATED REPRESENTATIVE OF LOCAL EDUCATION AGENCY **Date**

PRINT: