

**INDIVIDUALIZED EDUCATION PROGRAM**

STUDENT	DOB	AGE	SEX	SOCIAL SECURITY # / ID #
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PARENT(S)	ADDRESS	HOME PHONE	WORK PHONE
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SCHOOL DISTRICT	CURRENT GRADE
HOME SCHOOL	CURRENT SCHOOL
CONTACT PERSON'S NAME	PHONE NUMBER
STUDENT'S DOMINANT LANGUAGE	LANGUAGE OF THE HOME

INITIAL IEP	REVIEW	IEP EFFECTIVE FROM	TO
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**IEP PARTICIPANTS**

**PARTICIPANTS' SIGNATURES:** IEP team must include an individual who can interpret instructional implication of evaluation results.

Parent	Student		
Regular Education Teacher			
Special Education Teacher			
Local Educational Agency Rep			

**DESCRIPTION OF STUDENT'S STRENGTHS AND NEEDS IN THE GENERAL CURRICULUM:**

<b><u>STRENGTHS</u></b>	<b><u>NEEDS</u></b>
(continued on next page) <b><u>STRENGTHS</u></b>	<b><u>NEEDS</u></b>

Meeting Date(s)	Date of Birth:	page _____	of _____
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discussing needs to make sure to consider all of the following areas: Academic, Communicative, Motor, Sensory, Health/Physical Status, Behavior/Discipline, Emotional Social, Functional/Vocational. For students 14 or older: Employment, Post Secondary Education and Training, Independent Living, Community Participation.

**4) TRANSITION SERVICES:** Mus

be completed for all students 14 years of age, or younger, if appropriate.

When I exit school, I would like to be doing the following (long-term goals):

Employment:

Post Secondary Education & Training:

Independent Living:

Community Participation:

This is the course of study I will pursue in order to reach my long-term goals:

My needs in the Transition areas that are checked ( ) are addressed in my annual goals and objectives and are indicated in the column marked "TRANS

Employment:

Post-secondary Education and Training:

Independent Living:

Community Participation:

I do not have annual goals in the following areas (indicate with the check mark ( ) and this is why (Basis for Determination)):

Employment:

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Post-secondary Education and Training:

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Independent Living:

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Community Participation:

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I will need the assistance of the following agencies (other than my school) in order to reach my long-term goals:

**10) AGENCY:**

**11) CONTACT PERSON:**

**12) PHONE NUMBER:**

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3) PRESENT LEVELS OF PERFORMANCE: What do we know about this student?

4) ANNUAL GOALS: Goals should lead to the student being involved in and making progress in the general curriculum.

5) Short Term Objectives	16) Criteria	17) Objective Evaluation Procedure	18) Objective Evaluation Schedule	19) Trans	20) Progress Review/Rating*				21) Provider Location Service
					Nov	Jan	April	June	

2) PROGRESS TOWARD ANNUAL GOAL:

3) REASON(S) FOR NOT MEETING GOAL:

4) CONSIDERATION FOR EXTENDED SCHOOL YEAR: To be determined on or before \_\_\_\_\_ (date)

due to significant regression      due to emerging skill      other (define) \_\_\_\_\_      not needed for this goal

**DESCRIPTORS**

16) Criteria	17) Procedure	18) Schedule
time limit (e.g. within four minutes) percentage (e.g. 80) ratio of correct items (e.g. 8 out of 10) rubrics (e.g. 3 retell) specific criteria (e.g. 4 assignments) other	Written Observation Written Performance Oral Performance with Documentation Criterion-Reference Test Time Sample Demonstration/Performance Other	daily weekly monthly quarterly 2 out of 3 by November, by January, etc. Other
20) Progress Review	22) Reason(s) For Not Meeting Goal	23) Progress Toward Annual Goal
Attained Making Progress A Not Addressed at this time B Addressed No Progress	More time needed Excessive absence/tardiness Assignments not completed Needed to review/revise IEP Other (Specify) _____	Anticipate meeting goal Goal met (indicate date) Do not anticipate meeting goal (complete Reason For Not Meeting Goal column)

**21) DESCRIPTORS**

Provider (also 33)	Location/Placement (also 34)	Services (also 35)
Special Education Teacher Regular Education Teacher Speech/Language Therapist Occupational Therapist Physical Adaptive Physical Education Teacher School Nurse Teacher Rehabilitative Counselor Psychologist Job Coach Other	Regular Education Classroom Resource Room Therapy Room Self-Contained Classroom Day School Residential School Home Hospital Community Site Other	One on one Small group Whole class Consultation Other

5) SUPPLEMENTARY AIDES AND SERVICES TO SUPPORT CHILD (include assistive technology devices and services)

3) AREA(S)	27) GOAL #	28) DESCRIPTION (Include frequency and duration)	29) DATE		30) LOCATION
			FROM	TO	

MODIFICATIONS AND ACCOMMODATIONS TO SUPPORT CHILD

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SUPPORT TO SCHOOL PERSONNEL TO ASSIST CHILD

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6) AREA(S)

- |  |   |  |
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| <ul style="list-style-type: none"> <li>All subjects</li> <li>English/Language Arts</li> <li>Math</li> <li>Science</li> <li>Social Studies</li> </ul> | <ul style="list-style-type: none"> <li>f. Health</li> <li>g. PE</li> <li>h. Music</li> <li>i. Arts</li> <li>j. Library</li> </ul> | <ul style="list-style-type: none"> <li>k. Lunch</li> <li>l. Guidance Counseling</li> <li>m. School Sponsored/Extracurricular Activities</li> <li>n. Work/Community Based Learning</li> <li>o. Other</li> </ul> |
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**40) STATEMENT ON STATE/DISTRICT ASSESSMENT:**

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**a) Accommodations:\***

This student requires accommodations in statewide or district assessments of student achievement. Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, the individual accommodations needed (by specific assessment)

*Refer to RIDE accommodation policy*

**b) Alternate Assessment:\***

This student requires an alternate means of statewide and, if used, district assessment of student achievement. Yes \_\_\_\_\_ No \_\_\_\_\_

Describe why it is not appropriate for the student to participate with accommodations in state and/or district assessment.

*Refer to Ride criteria for eligibility.*

Describe the alternate means of district assessment that will be used to demonstrate the student's achievement.

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**41) REEVALUATION**

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**a) DATE FOR REEVALUATION \_\_\_\_\_**

Data Needed for Determination of Eligibility: this must be decided if reevaluation is due during the time frame of this IEP.

This is not consent to conduct an evaluation(s) but documentation of the team's discussion of data needed to determine eligibility.

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