

*Ionia County Intermediate School District*  
**Individualized Education Program Team (IEPT) Report**  
 (For students age 12 and under only)

IEP Date: _____	Birthdate: _____	Gender: _____
Prior IEP Date: _____	Grade: _____	Ethnicity: _____
Initial/3 Yr-Reevaluation IEP Date: _____	Student ID: _____	Native Lang: _____

Student's Last/First Name: _____		MI: _____
Address: _____	City: _____	State: <b>MI</b>
ZIP Code: _____	County: _____	Telephone: _____
Resident District: _____	Operating District: _____	Attending Bldg: _____
Parent/Guardian Name: _____		
Address (if different): _____		City: _____ State: <b>MI</b>
ZIP Code: _____	Telephone: _____	Work/Other: _____
Other Parent/Foster Parent/Case Worker: Name: _____		Relationship: _____
Address: _____		City: _____ State: _____
ZIP Code: _____	Telephone: _____	Work/Other: _____

**Purpose(s) of this IEP Team meeting is/are to discuss (check all applicable):**

- Initial Eligibility  Review/Revise IEP  3 Yr-Reevaluation  Change of Disability  Other, specify: \_\_\_\_\_

**Parent Invitations and Contacts:**

Method of contact: \_\_\_\_\_ By: \_\_\_\_\_ Date: \_\_\_\_\_ Result: \_\_\_\_\_  
 Method of contact: \_\_\_\_\_ By: \_\_\_\_\_ Date: \_\_\_\_\_ Result: \_\_\_\_\_

**IEP Team Meeting Participants in Attendance**

Check box  indicating IEP Team member who can explain the instructional implications of evaluation results.  
 Check circle  indicating IEP Team member who has observed the student suspected of having a learning disability.

Student	Adult Service Agency Representative	
Parent	General Education Teacher	<input type="checkbox"/> <input type="radio"/>
Parent	Special Education Teacher/Provider	<input type="checkbox"/> <input type="radio"/>
	Public Education Agency Representative/Designee	<input type="checkbox"/> <input type="radio"/>
		<input type="checkbox"/> <input type="radio"/>

**Participant signatures are required to verify a determination regarding a suspected learning disability under R340.1713. Any member who disagrees must submit a separate statement presenting his or her conclusion.**

**Eligibility for special education:** The IEP Team determined this student to be:  Ineligible  Eligible

Primary disability: \_\_\_\_\_

Secondary disability, if any: \_\_\_\_\_

Student:

Birthdate:

IEP Date:

**Factors to Consider in Order to Provide a Free and Appropriate Public Education (FAPE)**

Consider (check) each of the following and comment as appropriate:

- strengths of the student
- parent input and concerns for enhancing the education of the student
- results of an initial evaluation or the most recent reevaluation of the student
- progress on the current IEP annual goals and objectives
- student's anticipated needs or other matters

Comments:

Consider (check) each of the following. Needs in any of the following *require* a statement in the comments below.

- communication needs of the student
- positive behavior intervention, supports, and strategies for students whose behavior impedes learning
- language needs for students with limited English proficiency
- Braille instruction for students who are blind or visually impaired
- communication and language for students who are deaf or hearing impaired
- the need for assistive technology devices or services

**Present Level of Academic Achievement and Functional Performance**– in understandable terms: explain the data, areas of need, and how the disability affects his/her involvement and progress in the general education curriculum (or participation in appropriate activities for preschool students).

**Least Restrictive Environment** - This student will:

- Fully participate with students who are nondisabled in the general education setting except for the time spent in separate special education programs/services provided outside of the general education classroom as specified in this IEP.

Yes     No (explain): \_\_\_\_\_

- Be fully involved in and progress in the general education curriculum.

Yes     No (explain): \_\_\_\_\_

- Have the same opportunity as general education students to participate in nonacademic and extracurricular activities.

Yes     No (explain): \_\_\_\_\_

Student:

Birthdate:

IEP Date:

### Annual Goals and Short-Term Objectives

Data Used to Determine Present Level of Academic Achievement and Functional Performance:

Annual Goal: \_\_\_\_\_

Short-Term Objectives (at least two per goal)				Evaluation	Criterion	Schedules
1.						
2.						
3.						
Date	Status Obj. 1	Status Obj. 2	Status Obj. 3	Comments/Data On Progress		

Data Used to Determine Present Level of Academic Achievement and Functional Performance:

Annual Goal: \_\_\_\_\_

Short-Term Objectives (at least two per goal)				Evaluation	Criterion	Schedules
1.						
2.						
3.						
Date	Status Obj. 1	Status Obj. 2	Status Obj. 3	Comments/Data On Progress		

Evaluation	Criterion	Schedule	Status of Progress on Objectives
<b>S</b> Student's Daily Work <b>D</b> Documented Observation <b>R</b> Rating Scale <b>T</b> Standardized Test <b>O</b> Other (specify) _____ _____	_____% Accuracy ___of___ Rate _____ Achievement Level Other (specify) _____ _____	<b>W</b> Weekly <b>D</b> Daily <b>M</b> Monthly <b>G</b> Grading Period <b>O</b> Other (specify) _____ _____	<b>1</b> Achieved/Maintained <b>2</b> Progressing at a rate sufficient to meet the annual goal for this objective <b>3</b> Progressing below a rate sufficient to meet the annual goal for this objective (explain above) <b>4</b> Not applicable during this reporting period <b>5</b> Other (specify above)

Student:

Birthdate:

IEP Date:

### Supplementary Aids/Services/Personnel Support

The IEP Team has considered supplementary aids/services and supports as it relates to the student's disability. Needed services are listed below. Those on "consult" are required to provide written documentation upon expiration of this IEP.

Supplementary Aids/Services/Support	Amount of Time/Frequency/Conditions	Location/Subject

All supplementary aids/services and supports listed above will begin on the initiation date of the IEP and continue for one calendar year, following the approved school district calendar. Note below any exceptions to beginning and ending dates and locations given above.

Specify month/day/year: \_\_\_\_\_

### Special Education Programs /Related Services

Is there a need for a teacher with a particular endorsement?  No  Yes, specify:  
Resource Program Only – Is a Teacher Consultant with endorsement matching the student's disability needed?  No  Yes  
Departmentalized program (R 340.1832(1)(e))  No  Yes

Special Ed. Programs / Services Rule Number	Frequency / Duration	Provider Name (registry purposes only)	Location

All programs and services listed above will begin on the initiation date of the IEP and continue for one calendar year, following the approved school district calendar. Extended school year (ESY) services must be provided only if the IEP Team determines on an individual basis that ESY services are necessary for the provision of a free and appropriate public education. Note below any exceptions to beginning and ending dates and locations given above. Specify month/day/year: \_\_\_\_\_

Special Transportation:  No  Yes, specifics: \_\_\_\_\_

Nonpublic School Pupils - Identify programs/services offered by the district but not provided because the parent elected to enroll the child in a nonpublic school: \_\_\_\_\_

Reporting Progress:  The parents will be regularly informed in writing of progress on goals and objectives of this IEP at the regular reporting periods applicable to general education students. Additional reporting:  
How: \_\_\_\_\_ When: \_\_\_\_\_

For Registry Purposes Only:

Total School Hours: \_\_\_\_\_ Hours in General Education: \_\_\_\_\_ Hours in Special Education: \_\_\_\_\_

### State- and District-wide Assessment

The student will participate in the Michigan Educational Assessment System (MEAS), district-wide assessment, and/or the National Assessment of Educational Progress (NAEP\*) assessments as follows:

**I. Michigan Educational Assessment System (MEAS)**

MEAP, MME, or MI-ACCESS are not given at the grade levels covered by this IEP (grade levels K-2, 10, 12)

Assessments	M E A P  ----- MME	M I C E S S	<ul style="list-style-type: none"> <li>List needed assessment accommodations for each content area.</li> <li>State reason why MEAP is not appropriate for content areas, and state why MI-ACCESS is appropriate.</li> </ul>	*Standard Accommodations?	
				Yes	No
ELA (grades 3-8,11)	<input type="checkbox"/>	N/A		<input type="checkbox"/>	<input type="checkbox"/>
Mathematics (grades 3-8,11)	<input type="checkbox"/>	N/A		<input type="checkbox"/>	<input type="checkbox"/>
**Science (grades 5,8,11)	<input type="checkbox"/>	N/A		<input type="checkbox"/>	<input type="checkbox"/>
**Social Studies (grades 6,9,11)	<input type="checkbox"/>	N/A		<input type="checkbox"/>	<input type="checkbox"/>
Functional Independence	N/A	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Supported Independence	N/A	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Participation	N/A	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

\*Scores received using a non-standard assessment(s) accommodations are not eligible for the Michigan Merit Award. Also, per No Child Left Behind (NCLB), the student will not count as assessed in science and/or social studies until the state has alternate assessments in these content areas available.

\*\* If the MEAP science and/or social students assessment(s) are not appropriate for the student, indicate how the student will be assessed until the state has alternate assessments in these content areas available.

**II. English Language Proficiency Assessment (ELPA)**

The student is an English Language Learner and has been in the United States for \_\_\_ number of years. Therefore, the student will participate in the ELPA.

**III. District-wide and/or NAEP Assessments**

District-wide assessments are not given at the age/grade levels covered by this IEP.

The NAEP Assessments *ARE* administered at the grade level covered by this IEP and this student was selected as part of the sample

District-wide or NAEP Assessment	Assessment Appropriate?		List appropriate assessment accommodations if needed. If <b>not participating</b> , state the reason why the district-wide/NAEP assessment is inappropriate and indicate the appropriate alternate assessment.
	Yes	No	
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

Student:

Birthdate:

IEP Date:

**Additional Comments:**

Parent has signed the *Medicaid Authorization & Parent Consent* form.

**Commitment Signatures**

Any IEP Team member may submit a dissenting report for attachment to the IEP Team report.

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

- |                                                                                                                |                                                         |
|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Agrees with the IEP and its implementation                                            | <input type="checkbox"/> Disagrees with this IEP and:   |
| <input type="checkbox"/> Authorizes the nonresident operating district to conduct subsequent IEP Team meetings | <input type="checkbox"/> Requests mediation             |
| <input type="checkbox"/> Agrees that the student is not eligible for special education                         | <input type="checkbox"/> Requests a due process hearing |

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Resident District Superintendent or Designee month/day/year

**Non-resident Operating District - The superintendent/designee (check all that apply):**

- |                                                                                        |                                                         |
|----------------------------------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Agrees to provide the IEP program(s) and/or service(s)        | <input type="checkbox"/> Disagrees with this IEP and:   |
| <input type="checkbox"/> Agrees to conduct subsequent IEP Team meetings                | <input type="checkbox"/> Requests mediation             |
| <input type="checkbox"/> Agrees that the student is not eligible for special education | <input type="checkbox"/> Requests a due process hearing |

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Operating District Superintendent or Designee month/day/year

**Operating District Notice Requirements - The superintendent or designee of the operating district assures 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 child with a disability will not be removed from education in age-appropriate regular classrooms solely because of needed accommodations in the general curriculum.

Staff responsible for implementation: \_\_\_\_\_ Initial implementation site: \_\_\_\_\_

Beginning date (m/d/y): \_\_\_\_\_ Ending date(m/d/y): \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Superintendent or Designee month/day/year

**Adult Providing IEP Consent - I have been informed of all procedural safeguards and sources to obtain assistance, and:**

- |                                                                    |                                                                                  |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------|
| <input type="checkbox"/> Understand the contents of this IEP       | <input type="checkbox"/> Disagree, but will allow implementation of this IEP     |
| <input type="checkbox"/> Agree with the IEP and its implementation | <input type="checkbox"/> Disagree with this IEP and:                             |
|                                                                    | <input type="checkbox"/> Request mediation                                       |
|                                                                    | <input type="checkbox"/> Would like more information about a due process hearing |

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Adult Providing Consent month/day/year

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



**Ionia County Intermediate School District**

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Phone (616) 527-4900 • Fax (616) 527-4731  
[www.ioniaisd.org](http://www.ioniaisd.org)

**Medicaid Authorization & Parent Consent**

Student: Birthdate:  
Resident District: Primary Disability:  
School Building:

**Medicaid School-Based Services:**

The Social Security Act, as amended in 1988 by the Medicare Catastrophic Coverage Act, specifically provides for medical assistance (Medicaid) to cover services that are included in the student’s IEP or IFSP pursuant to the Individuals with Disabilities Education Act (IDEA). The program identifies medically necessary services already provided to schools e.g. speech therapy, social work, nursing, occupational therapy, physical therapy, and psychological services, and allows the school, as a service provider, to bill under Medicaid, thus ensuring federal participation in the cost of providing these services. All special education students who are Medicaid eligible are included under this act. Enrollment by a school district for Medicaid billing is not expected to result in any change in the student’s program or services provided by the school district or any other agency.

According to your child’s IEP dated, , s/he will receive services that are eligible for reimbursement under the state’s Medicaid program as specified in the IEP.

**Consent to Bill Medicaid (Parent to read, sign, & date)**

*Effective October 13, 2006, local school districts must obtain parent consent to access the Medicaid benefits for reimbursement of school-based special education related services [34 CFR §300.154(d)]. In addition, school districts must also notify parents that if they refuse to grant consent for Medicaid service reimbursement that all special education services will continue to be provided at no cost to the parents [34 CFR §300.9(B)].*

I authorize (as applicable) the school district to disclose to *Public Consulting Group, Inc. (PCG)* the following information: my child’s name, date of birth, assigned unique student number, eligibility as a student with a disability, the type(s) and number of services provided, the service date(s), and name of the provider(s). This information may be disclosed for the purpose of processing a claim to the Medical Services Administration in the Michigan Department of Community Health for Medicaid reimbursement for these services.

I agree to allow the school district to seek Medicaid reimbursement for special education related services for my child and I understand that personally identifiable student information is needed to submit a claim which will be kept confidential. I understand that my consent and authorization is voluntary and may be revoked at any time. I understand that if I refuse to allow access, the district is not relieved of its responsibility to ensure that these services are provided at no cost to me.

\_\_\_\_\_  
Parent/Guardian Signature Date