

Individualized Education Program (IEP) - TRANSITION

State of Delaware

School District
302-

Student Information

Student Name: _____	Date of Birth: _____
Student ID#: _____	Current Grade: _____
Address: _____	
District of Residence: _____	Attending Building: _____
Disability Classification: _____	

Parent* 1: _____	E-mail: _____
Address (if different): _____	(Cell) _____
Telephone (Home): _____ (Work) _____	
Parent* 2: _____	E-mail: _____
Address (if different): _____	(Cell) _____
Telephone (Home): _____ (Work) _____	

IEP Status

Meeting Date	_____	Most Recent Evaluation Summary Report Date	_____
IEP Initiation Date	_____	IEP Revision Date	_____
IEP End date	_____	IEP Revision Date	_____

Temporary Placement

Agency Representative:	_____
Parent:	_____
Date:	_____
<i>Within 60 days, an IEP meeting must be held</i>	

Meeting Participants

Role	Name	Signature
Parent* 1		
Parent* 2		
Student		
General Ed. Teacher		
Special Ed. Teacher		
Administrator / Designee		

* Parent includes legal guardian, educational surrogate parent and relative caregiver.

Name: _____ Date: _____

Data Considerations

1. What are the student's strengths?

Employment Strengths:

Post-Secondary Education/Training Strengths:

Independent Living Strengths:

2. What are the educational concerns of the parent (or student, if appropriate)?

3. What data sources and age appropriate transition assessments (including district or statewide assessments) are being used to create this IEP?

- ☐ Survey/Questionnaires and date administered _____
- ☐ Profiles/Portfolios _____ and date administered _____
- ☐ Vocational Assessment: _____ and date administered _____
- ☐ Student Success Plan: and date administered _____
- ☐ Other: _____ and date administered _____

4.	How does the child's disability affect the child's involvement and progress in the general education curriculum?
5.	What are the child's other educational needs that result from the child's disability (e.g., organizational skills, self care, fine/gross motor)?
6.	Will the student participate with non-disabled students in extracurricular and non-academic areas? If yes, identify supports and services on the "Needs, Services and Annual Goals" page. If no, explain why below.

Other Factors to Consider:

IEP team must consider each of the factors.

If there is a need identified, check "yes" and address in the IEP.

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Communication needs of the student
<input type="checkbox"/>	<input type="checkbox"/>	Braille instruction for students who are blind or visually impaired
<input type="checkbox"/>	<input type="checkbox"/>	Communication and language needs for students who are deaf/hard of hearing
<input type="checkbox"/>	<input type="checkbox"/>	Language needs for students with limited English proficiency
<input type="checkbox"/>	<input type="checkbox"/>	Positive behavior interventions, supports, and strategies for students whose behavior impedes learning
<input type="checkbox"/>	<input type="checkbox"/>	Need for assistive technology devices and services
<input type="checkbox"/>	<input type="checkbox"/>	Intervention supports and strategies for students who have difficulty accessing and/or using grade-level textbooks and other core materials in standard print formats

Name: _____ Date: _____

Transition

Student's Post-High School Goals:

Post School Employment Goal			
Post Education/Training			
Independent Living (if needed)			
The student plans to exit school with:	<input type="checkbox"/> Diploma	<input type="checkbox"/> Certificate	

Courses of Study:

Grade	Courses of Study (from student's current year to year of graduation)

_____	_____
_____	_____
_____	_____
_____	_____

Activities and Services to Reach Goal:

Employment Goal:				
Activities/Services needed to reach goal	Responsible Party		Start Date	Completion Date
			_____	_____
=====	=====		=====	=====
=====	=====		=====	=====
Post-Secondary Education/Training Goal:-				
Activities/Services needed to reach goal – See description above	Responsible Party		Start Date	Completion Date
_____	_____		_____	_____
=====	=====		=====	=====
=====	=====		=====	=====
Independent Living Goal (if needed):				
Activities/Services needed to reach goal – See description above	Responsible Party		Start Date	Completion Date
_____	_____		_____	_____
=====	=====		=====	=====
=====	=====		=====	=====

In addition to School Supports, the Student Will Need the Assistance of:

Agency	Contact Person	Phone Number
=====	=====	=====
=====	=====	=====

Is there a current Interagency Release of Information Form on file with the school?

☐ Yes ☐ No (If no, discuss form for transition planning with appropriate agencies)

Name: _____ Date: _____

Unique Educational Needs and Characteristics	Provide a statement of the special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable, to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will enable the child:			
	<ul style="list-style-type: none"> • to advance appropriately toward attaining the annual goals; • to be involved in and make progress in the general education curriculum, and to participate in extracurricular and other nonacademic activities; and, • to be educated and participate with other children with disabilities and non disabled children. 			
Services, Aids & Modifications	Start Date	Frequency	Duration	Location
		_____	_____	_____
		_____	_____	_____
		_____	_____	_____
		_____	_____	_____
		_____	_____	_____

PLEP (Present Level of Education Performance):

~~DE Admin Code §925.20.1.1~~

~~Add a present level of educational (academic or functional) performance here. There should be a direct relationship between the PLEP and the annual goal. "Not yet measured" or "no baseline" is not an appropriate PLEP. The PLEP should be measurable, based upon data of the child's current performance.~~

Benchmark #1

~~Description: Benchmarks are the steps needed to measure the annual goal. There should be a direct line from the PLEP (above) and the statement of special education services (above) towards the measurable annual goal (below). The marking period drop down should match to the next marking period that would occur during this IEP cycle. Measured progress must be reported to parents at least as often as it is reported to parents of non-disabled children.~~

Benchmark #2

Benchmark #3

Benchmark #4

Annual Goal:

M – Mastered **Annual Goal** S – Sufficient progress to meet **Annual Goal** N – Not sufficient progress to meet **Annual Goal**

Therapist Signature _____ Date: _____ (For Medicaid Cost Recovery)
 Transition IEP _____ Needs, Services and Annual Goals _____ 5/2010

Name: _____ Date: _____

Related Services

Services	Type of Delivery	Start/End Date	Frequency	Duration	Location
_____			_____	_____	_____
_____			_____	_____	_____
_____		_____	_____	_____	_____
_____		_____	_____	_____	_____
_____		_____	_____	_____	_____
_____		_____	_____	_____	_____
_____		_____	_____	_____	_____
_____		_____	_____	_____	_____
_____		_____	_____	_____	_____
_____		_____	_____	_____	_____

Name: _____ Date: _____

Transportation

Special transportation needs? If yes, specify: _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is it necessary to place this student, who is transported from the school by bus into the charge of a parent or other authorized responsible person? If so, Transportation Department will be notified by: _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Participation in Statewide Assessment

<input type="checkbox"/>	Student will participate in regular testing conditions without accommodations unless one of the below is checked.
<input type="checkbox"/>	Student participates with accommodations as documented on the attached Student Accommodation Checklist.
<input type="checkbox"/>	Student is included in Alternate Assessment. The Participation Guidelines form is attached and #500 is filled in on the Student Accommodation Checklist.
<input type="checkbox"/>	Student is not in a grade that is assessed.

Discipline

The student will adhere to School Code of Conduct. (Check below if any of the following are needed):	
<input type="checkbox"/>	Interventions and supports are described under services/supports and/or in goals.
<input type="checkbox"/>	Behavior intervention and support plan (see attached).
<input type="checkbox"/>	Other: _____

Participation in Twelve-Month Program

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
By State Law [14 Del.C. §1703], parents of students with certain disability classifications may choose a 12-month program which does not exceed 217 school days (Severe Mental Disability; Trainable Mental Disability; Orthopedic Impairment; Traumatic Brain Injury; Deaf-Blind) or 241 school days (Autism). As a parent of a qualifying student, I choose a 12-month program.

Consideration of Eligibility for Extended School Year Services (ESY)

IEP team must consider each of the following factors:					
• Regression / Recoupment		• Vocational Skills		• Degree of Impairment	
• Breakthrough Skills		• Extenuating Circumstances			
Is ESY needed?					
<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> To Be Determined	
<input type="checkbox"/> ESY offered, but declined by parent					
Rationale for decision: _____					
Specify goals and services: _____					
<input type="checkbox"/> See attached page (if needed)					
Services	Type	Start/End Date	Frequency	Duration	Location
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Name: _____ Date: _____

Least Restrictive Environment/Placement

A student with a disability shall not be removed from education in age appropriate regular classes solely because of needed modifications in general education curriculum. Special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

Use the option below to determine the appropriate setting.

<input type="checkbox"/>	A.	Regular Setting Includes pull-out related services and team classrooms. Student served inside the regular classroom greater than or equal to 80% of the day.
<input type="checkbox"/>	B.	Services Provided Both in Separate Special Education Classes and Regular Setting Student served inside the regular classroom greater than or equal to 40% of the day and no more than 79% of the day.
<input type="checkbox"/>	C.	Separate Special Education in an Integrated Setting Student served inside the regular classroom less than 40% of the day.
<input type="checkbox"/>	D.	Separate School Student served in public or private separate day school facility for greater than 50% of the school day or a residential facility if student does not live at the facility.
<input type="checkbox"/>	E.	Residential Facility where student resides during the school week.
<input type="checkbox"/>	F.	Homebound or Hospital
<input type="checkbox"/>	G.	Correctional Facilities (only used by DSCYF and Prison Education) Students placed in short-term detention or correctional facilities.

An explanation must be provided about the extent, if any, to which the child will not participate with nondisabled children in the regular class.

Student Parent Signatures

<input type="checkbox"/> Yes	<input type="checkbox"/> No	I acknowledge that I have received a copy of the Procedural Safeguards. My due process rights under those Procedural Safeguards have been explained to me.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	I agree with the program described in this document.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	I agree with the placement decision as noted above and discussed at this meeting.
<input type="checkbox"/> Yes	<input type="checkbox"/> N/A	At least one year before the age of majority (18), student has been informed that rights will transfer to him/her unless a legal guardian has been appointed.

Parent/ Student Signature

Date

Parent/ Student Signature

Date

If Parent Does Not Attend

Staff member below is responsible for forwarding a copy of the IEP and Procedural Safeguards and explaining content, if necessary to the Parent.

Name _____ Position _____ Method of Contact _____