(Insert District Name and Logo)

VALUATION PLANNING

☐ **INITIAL ~OR~** ☐ **RE-ELIGIBILITY**

STUDENT: _____ **BIRTHDATE:** _____ **AGE:** _____ **GRADE:** _____ **SCHOOL:** _____

POSSIBLE DISABILITIES: _____ **IEP DATE:** _____ **ELIGIBILITY DATE:** _____ **COMPLETED BY:** _____

_____ **PLANNING MEETING DATE:** _____ **CASE MANAGER:** _____

ASSESSMENT	NEEDED FOR	CONDUCTED BY	NAME OF MEASURE(S)/ASSESSMENTS	DESCRIPTION OF MEASURE(S)/ASSESSMENTS
File Review	All			
Developmental History	ASD, ID, EBD, TBI			
Guided Credible History Parent Interview	TBI			
House Bill 4140 TBI Accommodations Form	TBI			
Cognitive	ID, DD, TBI, as impacted for other			
Preinjury Performance	TBI			
Medical Statement	ASD, EBD, HI, ID, OI, OHI, TBI, VI			
Adaptive Rating	ASD, DD, ID, TBI			
Observation(s) in the classroom	ASD (1 of 3), DD, EBD (1 of 2), SLD, TBI (1 of 2)			
Observation(s) in another setting	ASD (2 of 3), DD, EBD (2 of 2), SLD, TBI (2 of 2)			
Observation(s) with Interaction	ASD (3 of 3)			
Academic	DD, OHI, SLD, as impacted for other			
Motor Assessments	OI, possibly: DD & TBI, as impacted for other			
Behavior Rating	ASD, DD, EBD (2), OHI, TBI, as impacted for other			
Social-Emotional	EBD			
Speech	ASD, CD, possibly: DD & TBI, as impacted for other			
Autism Rating Scale	ASD			

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Vision / Hearing	CD, HI, VI, ASD			
Additional Assessments	As needed to determine the impact of the suspected disability			
Signed Informed Consent	All	Attach a copy of the signed informed consent.		

Minutes

In attendance:

__, School Psychologist
__, SpEd Teacher
__, Parent/ Guardian
__, Gen Ed Teacher
__, Administrator
__, SLP
__, ASD Specialist
__, Teacher of the Deaf and Hard of Hearing
__, Teacher of the Visually Impaired and Orientation & Mobility Specialist

Gen Ed Teacher Input:

Parent Input:

SpEd Teacher Input:

Other Team Member Input:

☐ The Procedural Safeguards booklet was offered to the parent.