Individualized Education Program (IEP) – PRE-SCHOOL

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

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:	
Within 60 days, an IEP meeting must be held	

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?
2.	What are the educational concerns of the parent (or student, if appropriate)?
3.	What multiple data sources (including district or statewide assessments) are being used to create this IEP?
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)?

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	
☐	☐	Communication needs of the student
☐	☐	Braille instruction for students who are blind or visually impaired
☐	☐	Communication and language needs for students who are deaf/hard of hearing
☐	☐	Language needs for students with limited English proficiency
☐	☐	Positive behavior interventions, supports, and strategies for students whose behavior impedes learning
☐	☐	Need for assistive technology devices and services

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:** • **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):

_____

Benchmark #1 1st Reporting Period		**Progress** **Date:** _____
_____		*Report progress here for Benchmark #1* ☐M ☐S ☐N **Optional Narrative:** _____
Benchmark #2 1st Reporting Period		**Progress** **Date:** _____
_____		*Report progress here for Benchmark #2* ☐M ☐S ☐N **Optional Narrative:** _____
Benchmark #3 1st Reporting Period		**Progress** **Date:** _____
_____		*Report progress here for Benchmark #3* ☐M ☐S ☐N **Optional Narrative:** _____
Benchmark #4 1st Reporting Period		**Progress** **Date:** _____
_____		*Report progress here for Benchmark #4* ☐M ☐S ☐N **Optional Narrative:** _____

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)

Name: _____ Date: _____

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Related Services

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

Name: _____ Date: _____

Additional Considerations

Transportation

Special transportation needs? If yes, specify: ____	YES ☐	NO ☐
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 yes, Transportation Department will be notified by: ____	YES ☐	NO ☐

Discipline

The student will adhere to School Code of Conduct.
(Check below if any of the following are needed):

☐	Interventions and supports are described under services/supports and/or in goals.
☐	Behavior intervention and support plan (see attached).
☐	Other: ____

Participation in Twelve-Month Program

☐ Yes ☐ No ☐ 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?

☐ Yes ☐ No ☐ To Be Determined
☐ ESY offered, but declined by parent

Rationale for decision:

_____

Specify goals and services:

_____

☐ See attached page (if needed)

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

Name: _____ Date: _____

Educational Environments of Children with Disabilities Ages 3-5 (Check ONE)

(A) Children attending a regular early childhood program at least 10 hrs per week and the program includes at least 50 percent children without disabilities (children not on IEPs)
☐ (A1) and receiving the majority of hours of special education and related services in the regular early childhood program
☐ (A2) and receiving the majority of hours of special education and related services in some other location
(B) Children attending a regular early childhood program less than 10 hrs per week and the program includes at least 50 percent children without disabilities (children not on IEPs)
☐ (B1) and receiving the majority of hours of special education and related services in the regular early childhood program
☐ (B2) and receiving the majority of hours of special education and related services in some other location
(C) Children attending a special education program (NOT in any regular early childhood program) and the program includes less than 50 percent children without disabilities (children not on IEPs)
☐ (C1) specifically, a separate special education class
☐ (C2) specifically, a separate school
☐ (C3) specifically, a residential facility
(D) Children attending NEITHER a regular early childhood program NOR a special education program (NOT included in row sets A, B, or C)
☐ (D1) receiving the majority of hours of special education and related services at home. Report the child in this category even if the child also received special education and related services in a service provider location or some other location that is not in any other category.
☐ (D2) receiving the majority of hours of special education and related services at the service provider location or some other location not in any other category.
An explanation must be provided about the extent, if any, to which the child will not participate with children without disabilities in an early childhood program. _____

Student Parent Signatures

☐ Yes	☐ 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.
☐ Yes	☐ No	I agree with the program described in this document.
☐ Yes	☐ No	I agree with the placement decision as noted above and discussed at this meeting.

_____ _____

Parent Signature Date

_____ _____

Parent 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 _____