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| **STUDENT NAME:**         | **SIMS:**      |
| **PARENT/GUARDIAN NAME:**         | **PHONE:**      |
| **ADDRESS:**         | **WK PHONE:**      |
| **SCHOOL DISTRICT:**      | **SCHOOL:**      |
| **DOB:**      | **AGE:**      | **GRADE:**      |
| **GENDER:** \_\_\_\_\_\_\_\_\_\_\_ | **RACE:** \_\_\_\_\_\_\_\_\_\_\_ |
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| Meeting Date:      | **Purpose of Meeting**[ ]  Initial Eligibility, IEP, Placement[ ]  Annual Review of IEP[ ]  Three Year Reevaluation [ ]  Dismissal from Services - Date Effective:     [ ]  Parent Request[ ]  Other:      |
| Date Services Begin:      |
| Annual Review Date:      |
| Date of Eligibility Determination:      |
| Three Year Reevaluation Due By:      |

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| Discussed evaluation results/progress/assessment method [ ]  Yes     (Parent/Guardian initial)  | Student is eligible for special education or special education and related services as determined by the IEP team[ ]  Yes [ ]  No |
| Copy of evaluation results received [ ]  Yes     (Parent/Guardian initial) | An annual copy of Parent/Guardian Rights was received and reviewed    (Date)     (Parent/Guardian Initial) |
| Transition Planning Needed [ ]  No [ ]  Yes (\*If yes, attach applicable transition pages.) | A copy of the IEP was provided to parent/guardian [ ]  Yes     (Parent/Guardian Initial) |

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| **Primary Disability** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**:**  |

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| IEP Team Membership | **Signature** | **Date** |
| Parent/Guardian |  |  |
| Parent/Guardian |  |  |
| Student |  |  |
| School Representative |  |  |
| General Education Teacher |  |  |
| Special Education Teacher or Provider |  |  |
| Speech/Language Pathologist |  |  |
| Individual who can interpret evaluation results |  |  |
| Other:      |  |  |
| Other:      |  |  |
| Other:      |  |  |

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| **Present Levels of Academic Achievement and Functional Performance** |

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| In developing each student’s IEP, the IEP Team must consider 1) the strengths of the student; 2) the concerns of the parents for enhancing the education of their student; 3) the results of the initial or most recent evaluation of the student; and 4) the academic, developmental, and functional needs of the student.Provide a statement of the student’s present levels of academic achievement and functional performance, including 1) how the student’s disability affects the student’s involvement and progress in the general education curriculum (i.e., the same curriculum as for nondisabled students); or 2) for preschool students, as appropriate, how the disability affects the student’s participation in appropriate activities. |
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| \* Remember to address:* Strengths & needs using academic achievement (skill-based assessment) AND functional performance
* Parent input
* Transition strengths and needs including the student’s preferences and interests (must be in the student’s IEP by age 16)
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| **Consideration of Special Factors** |

**Is the student limited English proficient?** [ ]  Yes [ ]  No

If the answer to this question is “yes”, please explain the language needs of the student as these needs relate to the student’s IEP.

 **Are there any special communication needs?** [ ]  Yes [ ]  No

If the answer to this question is “yes”, please explain the communication needs of the student, and in the case of a student who is deaf or hard of hearing, consider the student’s language and communication needs, opportunities for direct communications with peers and professional personnel in the student’s language and communication mode, academic level, and full range of needs, including opportunities for direct instruction in the student’s language and communication mode.

i

 **Does the student require Braille?** [ ]  Yes [ ]  No

If the answer to this question is “yes”, what instruction in Braille and use of Braille will be provided?

**Does the student’s behavior impede his or her learning or that of others?** [ ]  Yes [ ]  No

If yes, what strategies are required to appropriately address this behavior, including positive behavioral interventions and supports?

**Does the student require Assistive Technology Devices and Services?** [ ]  Yes [ ]  No

If yes, what device or service will be provided?

**Physical Education:** [ ]  Regular [ ]  Not Required [ ]  Adaptive:

Refer to Goals/Goals & Objectives

**Hearing Aid Maintenance**: [ ]  Not Applicable [ ]  Yes: Personnel Responsible for Monitoring:

Describe the monitoring process/frequency necessary for maintenance:

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| **Educational Goals and Objectives/Benchmarks** |

Provide a statement of measurable annual goals, including academic and functional goals designed to 1) meet the student’s needs that result from the disability, 2) enable the student to be involved in and make progress in the general education curriculum, and 3) meet each of the student’s other educational needs that result from the disability.

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| Measurable Annual Goal #       |
|       | Proc. Code/s | Date | Prog.Code  | Comments: |
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| Procedure Codes (Complete at IEP meeting)1. Teacher-made tests 2. Work Samples3. Observations 4. Portfolios5. Tests 6. Data Response7. Other: | Progress Codes P= Progress being madeI= Insufficient Progress to meet goalX= Not addressed this Reporting PeriodM=Met goal | Reporting Frequency to Parents[ ]  Quarterly Reports[ ]  Trimester Reports [ ]  Other:      Reporting Method to Parents[ ]  Conferences [ ]  Report Card[ ]  Goal Page Copy [ ]  Other:       |

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| **Educational Goals and Objectives/Benchmarks** |

Provide a statement of measurable annual goals, including academic and functional goals designed to 1) meet the student’s needs that result from the disability, 2) enable the student to be involved in and make progress in the general education curriculum, and 3) meet each of the student’s other educational needs that result from the disability.

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| Measurable Annual Goal #       |
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| Short Term Instructional Objectives or Benchmarks (Required for students who take alternate assessment.) | Proc. Code/s | Date | Prog.Code | Comments: |
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| **Educational Goals and Objectives/Benchmarks** |

Provide a statement of measurable annual goals, including academic and functional goals designed to 1) meet the student’s needs that result from the disability, 2) enable the student to be involved in and make progress in the general education curriculum, and 3) meet each of the student’s other educational needs that result from the disability.

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| Measurable Annual Goal #       |
|       | Proc. Code/s | Date | Prog.Code  | Comments: |
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| Short Term Instructional Objectives or Benchmarks (Required for students who take alternate assessment.) | Proc. Code/s | Date | Prog.Code | Comments: |
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| Procedure Codes (Complete at IEP meeting)1. Teacher-made tests 2. Work Samples3. Observations 4. Portfolios5. Tests 6. Data Response7. Other: | Progress Codes P= Progress being madeI= Insufficient Progress to meet goalX= Not addressed this Reporting PeriodM=Met goal | Reporting Frequency to Parents[ ]  Quarterly Reports[ ]  Trimester Reports [ ]  Other:      Reporting Method to Parents[ ]  Conferences [ ]  Report Card[ ]  Goal Page Copy [ ]  Other:       |

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| **Accommodations and Modifications** |

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| Accommodations/Modifications/Supplementary Aides and Services1.
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3.
4.
5.
 | Frequency                          | Location                          | Duration                          |

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| Statement of the program modifications or supports for school personnel (as appropriate):                      | Frequency                | Location                | Duration                |

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| **State/District-wide Assessment Accommodations** |

**Assessment**

[ ]  Student will be taking state and district-wide assessments with or without accommodations.

[ ]  Student will be taking state and district-wide alternate assessments (The alternate assessment is for students working in the alternate achievement standards) (Annual goal and short-term objectives required)

1. Does the student meet the significant cognitive disability criteria? (If no, student is not eligible to take the alternate assessment) [ ]  Yes [ ]  No
2. Explain the reason why the student cannot participate in the regular assessment.

1. Explain the reason why the alternate assessment selected is appropriate for this student.

[ ]  No state and/or district-wide assessments are required at this student’s grade level during the course of this annual IEP.

**\*Teams must consider if the accommodations are approved for the applicable test administration.**

**\*List the accommodations the student will be taking for each test/test area.**

(Only those accommodations identified for instruction on the goal pages can be considered for state and district-wide testing. The accommodations selected for use must relate to the student’s disability.)

**State Assessment Accommodations**

**South Dakota ELA South Dakota Math South Dakota Science**

Assessment (Gr 3-8 & 11): Assessment (Gr 3-8 & 11): Assessment (Gr 5, 8 & 11):

**\* South Dakota Alt Assessments for ELA, Math, & Science**

Accommodations for both instruction and assessment must be documented.

South Dakota ELA-Alt South Dakota Math-Alt South Dakota Science-Alt

Assessment (Gr 3-8 & 11) Assessment (Gr 3-8 & 11) Assessment (Gr 5, 8 & 11)

**District-wide Assessment Accommodations**

Test:       Test:       Test:

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| **Special Education Services** |

Description of services Frequency Location Duration

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| --- | --- | --- | --- |
| Related Service to be Provided | Frequency | Location | Duration |
| [ ]  Speech/Language Therapy |       |       |       |
| [ ]  Occupational Therapy |       |       |       |
| [ ]  Physical Therapy |       |       |       |
| [ ]  Transportation (Specify when, how often, where, distance, costs, etc.) |       |       |       |
| [ ]  Counseling Services  (Including rehabilitation counseling) |       |       |       |
| [ ]  Audiological Services |       |       |       |
| [ ]  Interpreting Services |       |       |       |
| [ ]  Medical Services  (Diagnostic Services only) |       |       |       |
| [ ]  Orientation and Mobility |       |       |       |
| [ ]  Parent Counseling/Training |       |       |       |
| [ ]  Psychological Services |       |       |       |
| [ ]  Recreation Therapy |       |       |       |
| [ ]  School Nurse/Health Services |       |       |       |
| [ ]  Social Work Services (in schools) |       |       |       |
| [ ]  Other |       |       |       |

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| **Least Restrictive Environment** |

The IEP Team must ensure that, to the maximum extent appropriate, students with disabilities are educated with nondisabled peers, including extracurricular services and activities.

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| **Continuum of Alternative Placements (Ages 5-21)**[ ]  0100 General Classroom with Modifications 80-100%[ ]  0110 Resource Room 40-79%[ ]  0120 Self-Contained Classroom 0-39%[ ]  0130 Separate Day School[ ]  0140 Residential Facility[ ]  0150 Home/Hospital | **Continuum of Alternative Placements (Preschool Ages 3-5)**[ ]  0310 Early Childhood Setting-10 hrs.+/week services in Reg EC program[ ]  0315 Early Childhood Setting-10 hrs.+/week services in other location[ ]  0325 Early Childhood Setting-Less than 10hrs/wk. services in Reg EC program [ ]  0330 Early Childhood Setting-Less than 10hrs/wk. services in other location[ ]  0335 Special Education Class[ ]  0345 Separate School[ ]  0355 Residential Facility[ ]  0365 Home[ ]  0375 Service Provider Location |

**Participation with Non-Disabled Peers**

#### Program Options Non-Academic Extracurricular

[ ]  Art [ ]  Counseling [ ]  Athletics

[ ]  Career and Technical Ed [ ]  Meals [ ]  Clubs

[ ]  Music [ ]  Employment Referrals [ ]  Groups

[ ]  Early Childhood Program [ ]  Recess [ ]  Recreation

[ ]  Physical Education (PE) [ ]  Health Services [ ]  Other

[ ]  Other        [ ]  Other

Comments:

**Justification for Placement--An explanation of the extent, if any, to which the student will not participate with non-disabled students in regular classes and non-academic activities.**

(Please use accept/reject format for each alternative placement considered.)

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[ ]  *The team addressed the potential harmful effects of the special education placement.*

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| **Extended School Year** |

**Extended School Year Services:**  [ ]  needed [ ]  not needed [ ]  to be determined by (Date)

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| **Goal(s) #** | **\*Type of Service** | **Beginning Date****mm/dd/yy** | **Ending Date****mm/dd/yy** | **Minutes****Per Week** | **\*\*Based on**  |
|            |            |            |            |            |            |
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| \* Instruction, related services (specify), other (list)\*\* Regression/Recoupment, Emerging Skills, or Maintenance of Critical Life Skills |