**DISTRICT:**

**CHILD’S INFORMATION**

NAME:       ID NUMBER:

STREET:       GENDER:       GRADE:

CITY:       STATE: OH ZIP:

DATE OF BIRTH:

DISTRICT OF RESIDENCE: COUNTY OF RESIDENCE: DISTRICT OF SERVICE:

           

Is the child a ward of the state? YES  NO

If yes, provide the name of the surrogate parent:

**PARENT/GUARDIAN INFORMATION**

NAME:

STREET:

CITY:       STATE: OH ZIP:

HOME PHONE:       WORK PHONE:

CELL PHONE:       EMAIL:

NAME:

STREET:

CITY:       STATE: OH ZIP:

HOME PHONE:       WORK PHONE:

CELL PHONE:       EMAIL:

**OTHER INFORMATION**

|  |
| --- |
|  |

**MEETING INFORMATION**

MEETING DATE:

MEETING TYPE:

INITIAL SERVICES PLAN

ANNUAL REVIEW

REVIEW OTHER THAN ANNUAL REVIEW

AMENDMENT

OTHER:

**SERVICES PLAN TIMELINES**

ETR COMPLETION DATE:

NEXT ETR DUE DATE:

SERVICES PLAN EFFECTIVE DATES:

START:

END:

NEXT SERVICES PLAN REVIEW:

**SERVICES PLAN FORM STATUS**

(Check when complete)

1. MEASURABLE ANNUAL GOALS

2. SPECIALLY DESIGNED SERVICES

3. STATEWIDE AND DISTRICT TESTING

4. EXEMPTIONS

5. MEETING PARTICIPANTS

6. SIGNATURES

**AMENDMENTS:** (Complete only if amending the SP)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SP SECTION AMENDED | THE SCHOOL DISTRICT AND PARENTS HAVE AGREED TO MAKE THE FOLLOWING CHANGES TO THE SP | DATE OF AMENDMENT | PARTICIPANT & ROLE | INITIALS |
|  |  |  |  |  |

Click  to add new row

1

**MEASURABLE ANNUAL GOALS**

**NUMBER:** **AREA:**

**PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE**

|  |
| --- |
|  |

**MEASURABLE ANNUAL GOALS**

|  |
| --- |
|  |

**METHOD(S) FOR MEASURING THE CHILD’S PROGRESS TOWARDS ANNUAL GOAL**

**A. Curriculum-Based Assessment**  **E. Short-Cycle Assessments**  **I. Work Samples**

**B. Portfolios  F. Performance Assessments  J. Inventories**

**C. Observation  G. Checklists  K. Rubrics**

**D. Anecdotal Records  H. Running Records**

**MEASURABLE OBJECTIVES**

|  |  |  |
| --- | --- | --- |
| NUM | OBJECTIVE |  |
|  |  |  |

Click  above to add rows

**FREQUENCY OF WRITTEN PROGRESS REPORTING TOWARD GOAL MASTERY TO THE CHILD’S PARENTS**

*Note: Progress Reports must be provided to parents of a child with a disability at least as often as report cards are issued to all children. If the district provides interim reports to all children, progress reports must be provided to all parents of a child with a disability. See OP-6A Progress Report form.*

**Reported every****weeks**

**Click** **above to add new goal**

2

**DESCRIPTION(S) OF SPECIALLY DESIGNED SERVICES**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **TYPE OF SERVICE** | | **GOAL ADDRESSED** | **PROVIDER TITLE** | **LOCATION OF SERVICE** |
| **SPECIALLY DESIGNED INSTRUCTION** | | | | |
|  | |  |  |  |
| BEGIN: | END: | AMOUNT OF TIME: | | FREQUENCY: |

Click  above to add rows

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **RELATED SERVICES** | | | | |
|  | |  |  |  |
| BEGIN: | END: | AMOUNT OF TIME: | | FREQUENCY: |

Click  above to add rows

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ASSISTIVE TECHNOLOGY** | | | | |
|  | |  |  |  |
| BEGIN: | END: | AMOUNT OF TIME: | | FREQUENCY: |

Click  above to add rows

|  |  |  |
| --- | --- | --- |
| **ACCOMMODATIONS** | | |
|  | | |
| BEGIN: | END: |

Click  above to add rows

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| --- | --- | --- |
| **MODIFICATIONS** | | |
|  | | |
| BEGIN: | END: |

Click  above to add rows

|  |  |  |
| --- | --- | --- |
| **SUPPORT FOR SCHOOL PERSONNEL** | | |
|  | | |
| BEGIN: | END: |

Click  above to add rows

|  |  |  |
| --- | --- | --- |
| **SERVICE(S) TO SUPPORT MEDICAL NEEDS** | | |
|  | | |
| BEGIN: | END: |

Click  above to add rows

3

**STATEWIDE AND DISTRICT WIDE TESTING**

Is the child participating in the Alternate Assessment for Students with Significant Cognitive Disabilities (AASCD)? YES  NO

Click below for guidance in considering AASCD:

[Ohio’s Alternate Assessment Participation Decision-Making Tool](https://education.ohio.gov/Topics/Testing/Ohios-Alternate-Assessment-for-Students-with-Sign)

**Accessibility on district and statewide tests**

Will the child participate in district wide and statewide assessments with accommodations? YES  NO

|  |  |  |
| --- | --- | --- |
| For each subject tested in the child’s grade, choose the method of assessment below.  If “With Accommodations” is chosen for any subject, provide a description of the accommodations for each subject in the right column.  Alternate Assessment, if chosen, must apply to all tests taken. | | |
| **1. DISTRICT TESTING** (Note specific test or tests that student will be taking and any differences in allowable accommodations that may be test specific within the classroom across the district) | | |
| **AREA** | **ASSESSMENT TITLE** | **DETAIL OF ACCOMMODATIONS** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **2. STATEWIDE TESTING** (Note specific test or tests that student will be taking and any differences in allowable accommodations that may be test specific) | | |
| **AREA** | **ASSESSMENT TITLE** | **DETAIL OF ACCOMMODATIONS** |
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4

**EXEMPTIONS**

**Third Grade Reading Guarantee** (See [**The Ohio Third Grade Reading Guarantee Guidance Manual**](https://education.ohio.gov/Topics/Learning-in-Ohio/Literacy/Third-Grade-Reading-Guarantee/Third-Grade-Reading-Guarantee-District-Resources) for details)

Applicable  NA

Does the child have a significant cognitive disability? YES  NO

**If yes,** the child is not required to take the reading diagnostic assessment and is, therefore, removed

from all the provisions of the Third Grade Reading Guarantee (including retention).

**If no**, the team considered all data and made the following decision (check one):

Not to exempt the child from the retention provision of the Third Grade Reading Guarantee

To exempt the child from the retention provision of the Third Grade Reading Guarantee

**Graduation Tests**

Applicable  NA

Is the child excused from the consequences of not passing required graduation tests? YES  NO

The child is excused from the consequences of not passing the required graduation tests in the following subjects:

|  |  |  |
| --- | --- | --- |
| **Category** | **Course Title** | **Justification** |
|  |  |  |

Click  above to add rows

**Other Assessments**

Applicable  NA

|  |  |
| --- | --- |
| **Assessment** | **Justification** |
|  |  |

Click  above to add rows

5

**MEETING PARTICIPANTS**

**THIS SP MEETING WAS:**

Face-to-Face Meeting

Video Conference

Telephone Conference/Conference Call

Other

**SP EFFECTIVE DATES:**

START:

END:

DATE OF NEXT

SP REVIEW:

**SERVICES PLAN MEETING PARTICIPANTS**

THE FOLLOWING PEOPLE ATTENDED AND PARTICIPATED IN THE MEETING TO DEVELOP THIS SERVICE PLAN:

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME (Print)** | **POSITION** | **SIGNATURE** | **DATE** |
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Click  above to add rows

**PEOPLE NOT IN ATTENDANCE WHO PROVIDED INFORMATION AND RECOMMENDATIONS:**

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME (Print)** | **POSITION** | **SIGNATURE** | **DATE** |
|  |  |  |  |
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Click  above to add rows

\*IF THE GENERAL EDUCATION TEACHER, INTERVENTION SPECIALIST, DISTRICT REPRESENTATIVE OR PERSON KNOWLEDGEABLE ABOUT THE INSTRUCTIONAL IMPLICATIONS OF THE EVALUATION DATA HAVE SIGNED AS NOT IN ATTENDANCE AT THE SP MEETING, THERE MUST BE A WRITTEN EXCUSE ON FILE.

\*\*THE STUDENT IS A PREFERRED MEMBER UP TO AGE 18 WHEN THEY BECOME A REQUIRED MEMBER UNLESS THERE IS NO TRANSFER OF GUARDIANSHIP.

6

**SIGNATURES**

**INITIAL SP**

I give consent to initiate special education and related services specified in this SP. \*

I give consent to initiate special education and related services specified in this SP except for \*\*

AREA:

I do not give consent for special education and related services at this time. \*\*

**PARENT/GUARDIAN SIGNATURE:** **DATE:**

**SP ANNUAL REVIEW (Not a Change of Placement)**

I agree with the implementation of this SP \*

I am signing to show my attendance/participation at the SP team meeting, but I do not agree with the following special education and related services specified in this SP. \*\*

AREA:

*Note: Not a Change of Placement does NOT require a parent’s signature to implement the SP.*

**PARENT/GUARDIAN SIGNATURE:** **DATE:**

**SP REVIEW (Change of Placement)**

I give consent for the Change of Placement as identified in this SP. \*

I do not give consent for the Change of Placement as identified in this SP. \*\*

I revoke consent for all special education and related services. \*\*

**PARENT/GUARDIAN SIGNATURE:**  **DATE:**

**PROCEDURAL SAFEGUARDS NOTICE**

The parent received a copy of the Procedural Safeguards Notice at the SP Meeting in the following form:

YES  NO  **IF NO, DATE SENT TO PARENTS:**

**Transfer of Rights at Age of Majority**

By the child’s 17th birthday, the child and the child’s parents or guardian received a copy of their procedural safeguards notice informing them that the transfer of procedural safeguard rights under IDEA will take place on the child’s 18th birthday.

YES  NO

**CHILD’S SIGNATURE:**  **DATE:**

**PARENT/GUARDIAN SIGNATURE:**  **DATE**:

**COPY OF THE SERVICES PLAN**

The parents received a copy of the Services Plan at the SP meeting. YES  NO  IF NO, DATE SENT TO PARENTS:

\* The district must provide prior written notice to the parents summarizing the outcome of the SP meeting before implementing the SP.

\*\* If there is not agreement or consent is revoked, the district must provide prior written notice to the parents.