

SP Services Plan

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

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MEASURABLE ANNUAL GOALS

NUMBER: _____ AREA: _____

PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

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MEASURABLE ANNUAL GOALS

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

- | | | |
|---|---|--|
| <input type="checkbox"/> A. Curriculum-Based Assessment | <input type="checkbox"/> E. Short-Cycle Assessments | <input type="checkbox"/> I. Work Samples |
| <input type="checkbox"/> B. Portfolios | <input type="checkbox"/> F. Performance Assessments | <input type="checkbox"/> J. Inventories |
| <input type="checkbox"/> C. Observation | <input type="checkbox"/> G. Checklists | <input type="checkbox"/> K. Rubrics |
| <input type="checkbox"/> D. Anecdotal Records | <input type="checkbox"/> H. Running Records | |

Objectives

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

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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	GOAL ADDRESSED	PROVIDER TITLE	LOCATION OF SERVICE
BEGIN:	END:	AMOUNT OF TIME:	FREQUENCY:

Click  above to add rows


ASSISTIVE TECHNOLOGY	GOAL ADDRESSED	PROVIDER TITLE	LOCATION OF SERVICE
BEGIN:	END:	AMOUNT OF TIME:	FREQUENCY:

Click  above to add rows


ACCOMMODATIONS	GOAL ADDRESSED	PROVIDER TITLE	LOCATION OF SERVICE
BEGIN:	END:	AMOUNT OF TIME:	FREQUENCY:

Click  above to add rows


MODIFICATIONS	GOAL ADDRESSED	PROVIDER TITLE	LOCATION OF SERVICE
BEGIN:	END:	AMOUNT OF TIME:	FREQUENCY:

Click  above to add rows

SUPPORT FOR SCHOOL PERSONNEL	GOAL ADDRESSED	PROVIDER TITLE	LOCATION OF SERVICE
BEGIN:	END:	AMOUNT OF TIME:	FREQUENCY:

Click  above to add rows

SERVICE(S) TO SUPPORT MEDICAL NEEDS	GOAL ADDRESSED	PROVIDER TITLE	LOCATION OF SERVICE
BEGIN:	END:	AMOUNT OF TIME:	FREQUENCY:

Click  above to add rows

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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](#)

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
<input type="checkbox"/> ELA		
<input type="checkbox"/> Mathematics		
<input type="checkbox"/> Science		
<input type="checkbox"/> Social Students		
<input type="checkbox"/> Other:		

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
<input type="checkbox"/> ELA		
<input type="checkbox"/> Mathematics		
<input type="checkbox"/> Science		
<input type="checkbox"/> Social Students		
<input type="checkbox"/> Other:		

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EXEMPTIONS

Third Grade Reading Guarantee (See [The Ohio Third Grade Reading Guarantee Guidance Manual](#) 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

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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

Click  above to add rows

PEOPLE NOT IN ATTENDANCE WHO PROVIDED INFORMATION AND RECOMMENDATIONS:

NAME (Print)	POSITION	SIGNATURE	DATE

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.

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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.