

New York City Board Of Education Individualized Education Program

STUDENT INFORMATION

Name

Address

Phone NYC ID#

Date of Birth Age English LAB Year

Grade Gender Spanish LAB Year

Language(s) Spoken/Mode of Communication

Agencies with whom student is involved:

Name of Contact Phone

PARENT/GUARDIAN INFORMATION

Name(s) of Parent(s) Legal Guardian(s)

Address

Phone (Home) Phone (Work)

Preferred Language / Mode of Communication: Yes No

Interpreter Required Yes No

CONFERENCE INFORMATION

CSE Case#

Home District Service District

Date of Conference

Type of Conference

SPECIAL MEDICAL/PHYSICAL ALERTS

(Refer to Health & Physical Development Page for additional details)

The student has :

Medical Conditions and/or

Physical Limitations which affect his/her:

Learning

Behavior and/or

Participation in school activities

The student requires :

Medication and/or

Health care treatment(s)/procedure(s) during the day.

Other alerts:

This IEP includes :

Transition

Interim Service Plan

Summary Of Recommendations

Recommended Services Classification of Disability:

Eligibility yes no

Twelve Month School year: Yes No

Staffing Ratio

Recommended Services - Twelve Month School Year

Program Accessibility* Adapted Phys. Ed.*

Related Services* Assistive Technology*

Special Education Transportation -Comment

Students who are *blind* or *visually impaired* : Yes No

Braille instruction needed Yes No

*Details are provided in relevant sections of IEP.

Other Recommendations (Check all that apply)

Bilingual Instruction

Monolingual Services with ESL

Monolingual Services without ESL

Students who are deaf or hard of hearing:

Language of Instruction

Mode of Communication

CONFERENCE INFORMATION

Referral type: Initial Annual Review
 Triennial Requested Review

Conference type: EPC Annual Review
 CSE Review CPSE Review

Attendance at Conference

Please note that your signature reflects your participation at the conference and does not necessarily indicate agreement with the Individualized Education Program.

Signature/Title	Role (Indicate if Bilingual)	Signature/Title	Role (Indicate if Bilingual)
_____	Parent/Legal Guardian	_____	Parent/Legal Guardian
_____	District Representative	_____	Special Education Teacher or Related Service Provider
_____	General Education Teacher	_____	Parent Member (CPSE/CPSE)
_____	Student	_____	Other
_____	Education Evaluator	_____	Other
_____	School Psychologist	_____	Other
_____	Social Worker	_____	Other

Use an asterisk (*) to signify the participant who interprets the instructional implications of evaluation results.
 Use the letter (T) to signify participation by teleconference.

Conference Results

Initiate Service Modify Service Change Program / Service Category No Change

Indicate Modifications

Initiation, Duration, and Review of IEP

Projected Date of Initiation of IEP: Projected Date Of Review of IEP:
 Duration of Services:

Contacts with Parent / Guardian

Date Notice of Meeting Sent: Date IEP and Notice of Recommendation
 Date of Follow-up (if any): Type of Follow-up
 Letter Telephone Given To Parent:
 Letter Telephone Sent To Parent:

CONFERENCE INFORMATION

Referral type: Initial Annual Review EPC Annual Review
 Triennial Requested Review CSE Review CPSE Review

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_____	Parent/Legal Guardian	_____	Parent/Legal Guardian
_____	District Representative	_____	Special Education Teacher or Related Service Provider
_____	General Education Teacher	_____	Parent Member (CPSE/CPSE)
_____	Student	_____	Other _____
_____	Education Evaluator	_____	Other _____
_____	School Psychologist	_____	Other _____
_____	Social Worker	_____	Other _____

Use an asterisk (*) to signify the participant who interprets the instructional implications of evaluation results.
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 Triennial Requested Review CSE Review CPSE Review

Attendance at Conference
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Signature/Title	Role (Indicate if Bilingual)	Signature/Title	Role (Indicate if Bilingual)
_____	Other	_____	Other
_____	Other	_____	Other
_____	Other	_____	Other
_____	Other	_____	Other
_____	Other	_____	Other
_____	Other	_____	Other
_____	Other	_____	Other

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Initiation, Duration, and Review of IEP

Projected Date of Initiation of IEP: Projected Date of Review of IEP:
 Duration of Services:

Date Notice of Meeting Sent:
 Date of Follow-up (if any): Type of Follow-up: Letter Telephone
 Letter Telephone

 Copy For: CSE PARENT SCHOOL STUDENT OTHER

ACADEMIC PERFORMANCE AND LEARNING CHARACTERISTICS

Describe the student's present levels of academic achievement, language development, cognitive development and learning style in English and the other than English language for LEP students. Discuss how the student's disability affects his/her involvement and progress in the general curriculum or, for preschool students, as appropriate, how the student's disability affects participation in appropriate activities.

PRESENT PERFORMANCE:

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Reading And Writing				Math					
Area	Date	Test/Evaluation	Score	Instructional Level	Area	Date	Test/Evaluation	Score	Instructional Level
Decoding					Computation				
Reading Comprehension					Problem Solving				
Listening Comprehension									
Writing									

ACADEMIC MANAGEMENT NEEDS

(Environmental modifications and human/material resources)

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Student: _____

NYC ID # _____

Date of Conference _____

ANNUAL GOALS AND SHORT-TERM OBJECTIVES CSE Case# _____

There will be _____ reports of progress this school year.

1st 2nd 3rd 4th 5th 6th 7th 8th

ANNUAL GOAL:	PROGRESS	Date Mon/Yr	1st	2nd	3rd	4th	5th	6th	7th	8th
	Methods of Measurement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Report of Progress		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Progress Toward Annual Goal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Reasons for not Meeting Annual Goal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SHORT-TERM OBJECTIVES:

Other: _____

ANNUAL GOAL:

PROGRESS	Date Mon/Yr	1st	2nd	3rd	4th	5th	6th	7th	8th
	Methods of Measurement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Report of Progress		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Progress Toward Annual Goal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Reasons for not Meeting Annual Goal		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SHORT-TERM OBJECTIVES:

Other: _____

METHODS OF MEASUREMENT

- Teacher Made Materials
- Standardized Test
- Class Activities
- Portfolio(s)
- Teacher/Provider Observations
- Performance Assessment Task
- Check Lists
- Verbal Explanation
- Other (Specify) _____

EXPLANATION OF CODING SYSTEM

REPORT OF PROGRESS

- Not applicable during this grading period
- No progress made
- Little progress made
- Progress made; goal not yet met
- Goal met

PROGRESS TOWARD GOAL

- Anticipate meeting goal
- Do not anticipate meeting goal (Note reason)
- Goal met

REASONS FOR NOT MEETING GOAL

- More time needed
- Excessive absence or lateness
- Assignments not completed
- Other(Specify) _____

*While a review of your child's educational program occurs every year please be advised that you have a right to request a review of your child's program at any time.

The student's performance is approaching his/her promotion criteria as set forth on page 9 of the IEP:

For students who are not anticipated to meet their annual goals and/or promotion criteria: We recommend that the IEP Team be reconvened:

1st 2nd 3rd 4th 5th 6th 7th 8th

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Use a Y (Yes) or N (No) in the appropriate column.

Copy For :

CSE _____

PARENT _____

SCHOOL _____

STUDENT _____

OTHER _____

SCHOOL ENVIRONMENT AND SERVICE RECOMMENDATIONS GENERAL EDUCATION ENVIRONMENT

Area of Instruction	Language(s) or Communication mode	Periods per week	Supplementary Aids and Service	Program Modifications and Supports for School Personnel

SPECIAL CLASS ENVIRONMENT

Area of Instruction	Language(s) or Communication mode	Periods per week	Special Class and Staffing Ratio	Supports	Reasons for Non-Participation in General Education Environment

PARTICIPATION IN SCHOOL ACTIVITIES, RELATED SERVICE RECOMMENDATIONS AND PARTICIPATIONS IN ASSESSMENTS

PARTICIPATION IN SCHOOL ACTIVITIES

If the student cannot participate in lunch, assemblies, trips and/or other school activities with non-disabled students, indicate the activity and reason(s) for non-participation.

Status*	Related Service	Language of service	Location**	Session/ week	Duration	Group size

* Indicates status of recommendation: Initiate; Continue; Modify; or Terminate ** Indicate whether service is provided outside the general education classroom

PARTICIPATION IN ASSESSMENTS

The student WILL PARTICIPATE in state and local assessments. The student will participate in Alternative Assessment.

Without Accommodations With Accommodations

Describe accommodations, if any that will be used consistently throughout the student's educational program:

In addition to Alternative Assessment, describe how the student will be assessed:

Promotion Standard Criteria Modified Criteria* **Promotion** * Describe the modified promotion criteria

PARTICIPATION IN SCHOOL ACTIVITIES, RELATED SERVICE RECOMMENDATIONS AND PARTICIPATIONS IN ASSESSMENTS

PARTICIPATION IN SCHOOL ACTIVITIES

If the student cannot participate in lunch, assemblies, trips and/or other school activities with non-disabled students, indicate the activity and reason(s) for non-participation.

Status*	Related Service	Language of service	Location**	Session/ week	Duration	Group size

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PARTICIPATION IN ASSESSMENTS

The student WILL PARTICIPATE in state and local assessments. The student will participate in Alternative Assessment.
 Without Accommodations With Accommodations
 Describe modifications, if any that will be used consistently throughout the student's educational program:

 In addition to Alternative Assessment, describe how the student will be assessed:

Promotion Standard Criteria Modified Criteria* **Promotion** * Describe the modified promotion criteria

Transition

LONG TERM ADULT OUTCOMES

(Beginning at age 14 or younger if appropriate, state long term outcomes based on the student's preferences, needs and interests.)

Community Integration: _____
Post-Secondary Placement: _____
Independent Living: _____
Employment: _____

Diploma Objective

Regents Diploma Advanced Regents Diploma Local Diploma IEP Diploma

Expected High School Completion Date _____ Credits Earned _____ As Of Date _____

Transition Services

(Required for students 15 years of age and older.)

Instructional Activities _____
Responsible Party: Parent School Student Agency _____ Fall Spring Summer
Community Integration _____
Responsible Party: Parent School Student Agency _____ Fall Spring Summer
Post High School _____
Responsible Party: Parent School Student Agency _____ Fall Spring Summer
Independent Living _____
Responsible Party: Parent School Student Agency _____ Fall Spring Summer

Acquisition of Daily Living Skills Functional Vocational Assessment Needed Not Needed

Responsible Party: Parent School Student Agency _____

**BOARD OF EDUCATION CITY OF NEW YORK
 DIVISION OF SPECIAL EDUCATION - DIVISION OF HIGH SCHOOLS
 INDIVIDUALIZED EDUCATION PROGRAM - PHASE I/PHASE II IEP UPDATE
 REFERRAL TO SBST/CSE FOR SUBSTANTIAL CHANGE IN PHASE I IEP
 TYPE 3 RECOMMENDATION**

A. STUDENT INFORMATION

A1 STUDENT'S NAME		D.O.B.	CSE CASE#		
ADDRESS		APT.	ZIP	HOME DISTRICT	
NYC ID#	DATABANK #	PARENT GUARDIAN NAME			
BORO/SERVICE DISTRICT	SCHOOL	CLASS CODE	PROGRAM CODE	LAB SCORE (%ILE)	

A2

Phase I/Phase II IEP Update Annual Review or

Phase I/Phase II IEP Update Requested Review

Requested by _____

Title _____

A3 DATE OF LAST PHASE 1-IEP /IEP UPDATE	A4 SERVICE CATEGORY/CLASS SIZE AND STAFFING <input type="checkbox"/> BASIC I
A5 HANDICAPPING CONDITION	A6 SPECIAL ALERTS <input type="checkbox"/> NONE

B. CONFERENCE INFORMATION

B1 DATE OF CONFERENCE _____ SIGNATURE OF ATTENDANTS: RELATIONSHIPS/TITLE:	B2 INTERPRETER OF THE DEAF/TRANSLATOR REQUIRED ? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES NAME _____ language _____ B3 PRIOR TEACHER CONTACTS WITH PARENT/GUARDIAN Date Notice Of Meeting Sent _____ Follow -Up (if necessary) _____ <input type="checkbox"/> LETTER <input type="checkbox"/> TELEPHONE DATE _____
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C. RECOMMENDATIONS/CHANGES TO PHASE 1-IEP UPDATE

C1 THE FOLLOWING MODIFICATIONS/CHANGE(S) ARE SUGGESTED: CHECK ONE OR MORE

- | | |
|--|--|
| <input type="checkbox"/> change of group size for related services | <input type="checkbox"/> change in handicapping condition |
| <input type="checkbox"/> change to specify counseling be provided by a particular discipline | <input type="checkbox"/> change from one program/service category to another |
| <input type="checkbox"/> initiation or termination of resource room services | <input type="checkbox"/> change in language of instruction from bilingual to monolingual |
| <input type="checkbox"/> initiation or termination of related service | <input type="checkbox"/> change in language of instruction from monolingual to bilingual |
| <input type="checkbox"/> increasing or decreasing the number of periods in resource room | <input type="checkbox"/> change in language of instruction from monolingual to ESL only |
| <input type="checkbox"/> termination of regular class programming | <input type="checkbox"/> Other |
| <input type="checkbox"/> initiation or change of test/category modifications* | |

*Other than extended time or alternative test location

OTHER: _____

C2 EXPLAIN BELOW SPECIFIC REASONS WHY THE ABOVE INDICATED CHANGE(S) IN THE STUDENT'S PHASE 1- IEP IS INDICATED (ATTACHED) (ATTACH PAGES OF THE PHASE 1IEP UPDATE AND OTHER DOCUMENTATION);

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D. SIGNATURES

D1	D2 (ANNUAL REVIEW ONLY)
_____ TEACHER /SERVICE PROVIDER	_____ Supervisor
Date	Date

__ CSE COPY __ PARENT COPY __ SPECIAL EDUCATION SCHOOL FILE COPY __ TEACHER COPY