SP Services Plan

CHILD'S INFORMATION

NAME: _____ ID NUMBER: _____

STREET: _____ GENDER: ____ GRADE: _____ / _____

CITY: _____ STATE: _____ 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: _____ 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 TIME LINES

ETR COMPLETION DATE: _____

NEXT ETR DUE DATE: _____

SP EFFECTIVE DATES

START: _____

END: _____

NEXT SERVICES PLAN REVIEW: _____

SP 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

1 MEASURABLE ANNUAL GOALS

NUMBER: _____ AREA: _____

PRESENT LEVEL OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

MEASURABLE ANNUAL GOAL

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

- ☐ A. Curriculum Based Assessment
- ☐ B. Portfolios
- ☐ C. Observation
- ☐ D. Anecdotal Records
- ☐ E. Short-Cycle Assessments
- ☐ F. Performance Assessments
- ☐ G. Checklists
- ☐ H. Running Records
- ☐ I. Work Samples
- ☐ J. Inventories
- ☐ K. Rubrics

Select Display Mode:

MEASURABLE OBJECTIVES

NUM	OBJECTIVE
.1	

MEASURABLE BENCHMARKS

NUM	BENCHMARK	DATE OF MASTERY
.1		

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.

Reported every _____ weeks

2 DESCRIPTION(S) OF SPECIALLY DESIGNED SERVICES

TYPE OF SERVICE		GOAL ADDRESSED	PROVIDER TITLE	LOCATION OF SERVICES
SPECIALLY DESIGNED INSTRUCTION:				
BEGIN:	END:	AMOUNT OF TIME:		FREQUENCY:
RELATED SERVICES:				
BEGIN:	END:	AMOUNT OF TIME:		FREQUENCY:
ASSISTIVE TECHNOLOGY:				
BEGIN:	END:	AMOUNT OF TIME:		FREQUENCY:
ACCOMMODATIONS:				
BEGIN:	END:			
MODIFICATIONS:				
BEGIN:	END:			
SUPPORT FOR SCHOOL PERSONNEL:				
BEGIN:	END:			
SERVICE(S) TO SUPPORT MEDICAL NEEDS:				
BEGIN:	END:			

3 STATEWIDE AND DISTRICT WIDE TESTING

Met testing participation requirement? ☐YES ☐NO Date Complete: _____

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 AASCD Participation Criteria

If yes, justify the choice of alternate assessment and address why it is appropriate below:

Accessibility on district and statewide tests

Will the child participate in district wide and state wide 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)

AREA	ASSESSMENT TITLE	DETAIL OF ACCOMMODATIONS
☐ ELA		
Reading ☐		
Writing ☐		
☐ Mathematics		
☐ Science		
☐ Social Studies		
☐ 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
☐ ELA		
Reading ☐		
Writing ☐		
☐ Mathematics		
☐ Science		
☐ Social Studies		
☐ Other		

4 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, then 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, all data was considered and the following decided (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 to be 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

Other Assessments

Applicable ☐ NA ☐

Assessment	Justification

5 MEETING PARTICIPANTS

THIS SERVICES PLAN MEETING WAS:

- ☐ Face-to-Face Meeting
- ☐ Video Conference
- ☐ Telephone Conference/Conference Call
- ☐ Other

SERVICES PLAN EFFECTIVE DATES

START: _____

END: _____

DATE OF NEXT SERVICES PLAN REVIEW: _____

SERVICES PLAN MEETING PARTICIPANTS

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

NAME (Print)	POSITION	SIGNATURE	DATE

PEOPLE NOT IN ATTENDANCE WHO PROVIDED INFORMATION AND RECOMMENDATIONS

NAME (Print)	POSITION	SIGNATURE	DATE

*IF THE GENERAL EDUCATION TEACHER, INTERVENTION SPECIALIST, DISTRICT REPRESENTATIVE OR PERSON KNOWLEDGABLE ABOUT THE INSTRUCTIONAL IMPLICATIONS OF THE EVALUATION DATA HAVE SIGNED AS NOT IN ATTENDANCE AT THE SP MEETING, A WRITTEN EXCUSE MUST BE ON FILE.
**THE STUDENT IS A PREFERRED MEMBER UP TO AGE 18 WHEN THEY BECOME A REQUIRED MEMBER UNLESS 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 parents' 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

A copy of the Procedural Safeguards Notice was given to the parents at the Services Plan 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 surrogate parent 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

A copy of the Services Plan was given to the parents 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.