INDIVIDUAL EDUCATION PROGRAM / SERVICE DELIVERY PLAN
(To be completed after the IEP is developed)

Student: _____
School: _____

Check Purpose
☐ Initial Entry
☐ Annual Review
☐ Reevaluation
☐ Change in Placement
☐ Other:_____

II. AREA OF IDENTIFICATION (ELIGIBILITY) (mark only primary condition)

☐ Academically Gifted
☐ Autistic
☐ Behaviorally-Emotionally Handicapped
☐ Deaf-Blind
☐ Hearing Impaired
☐ Mentally Handicapped
☐ Other Health Impaired
☐ Specific Learning Disabled
☐ Speech - Language Impaired
☐ Traumatic Brain Injured
☐ Visually Impaired
☐ Preschool Developmentally Delayed
☐ EMH ☐ S/PMH ☐ TMH
☐ Multihandicapped
☐ Orthopedically Impaired

* Child meets the eligibility criteria of the State Board of Education and is in need of special education.

II. RELATED SERVICES

☐ Audiology
☐ Counseling Services
☐ Occupational Therapy
☐ Physical Therapy
☐ Speech- Language
☐ Transportation
☐ Other _____
_____
☐ None

III. LEAST RESTRICTIVE ENVIRONMENT (PLACEMENT)

A. Amount of Time in Exceptional Education

Type of Service	**Sessions Per Wk./Mo./Yr.**	**Min. per Session**	**Hours Per Wk.**
Consultation Direct			
Special Education			
Related Services			

B. Continuum of Services: Check the services considered by the committee, and check the decision reached. Give reason(s) for the decision reached. A continuum of services must be considered.

☐ Regular – Less than 21% of day
☐ Resource - 21% - 60% of day
☐ Separate – 61% or more of day
☐ Public Separate School – 100%
☐ Private Separate School – 100%
☐ Public Residential – 100%
☐ Private Residential – 100%
☐ Home / Hospital – 100%

PRESCHOOL

☐ Regular- *Up to 6 hours per week
☐ Resource - *6 to 12 hours per week
☐ Separate - *more than 12 hours per week
☐ Public Separate School – 100%
* Applicable only in a classroom setting
☐ Private Separate School – 100%
☐ Public Residential – 100%
☐ Private Residential – 100%
☐ Home / Hospital – 100%
☐ Home / Family – minimum 1 hour per week

AGENCY: Check where the student is receiving special services.

☐ 1. LEA/School in Attendance Area
☐ 2. LEA/School Note in Attendance Area
☐ 3. Another LEA
☐ 4. Other _____

The committee reviewed the full continuum of services, considered those checked above, and selected this setting because:

_____
_____
_____

C. Regular Program Participation: Circle the regular class (es) in which the student is enrolled and list the letter(s) for any modification(s) in the lank provided.

____ Reading	___ Library	___ History	_____ For. Language	___ Vocation
____ English	___ Music/Art	___ Science	_____ Physical Educ.	___ Recess
____ Spelling	___ Economics	___ Health	_____ Chapter I	___ Homeroom
____ Math	___ Social Studies	___ Writing	_____ Remediation	___ Other
____ Language Arts	___ Lunch	___ Assemblies		

Appropriate classroom modification(s), if any:

a. Grading	e. Alternative Materials	i. Interpreter	m. Other
b. Peer Tutoring	f. Extended Test Time (T chr. Test)	j. Auditory Trainer	_____
c. Oral Test	g. Large Print Books	k. Assistive Devices	_____
d. Abbreviated Assign.	h. Audio Tapes	l. Computer/Typewriter/ Word Processor	_____

For preschool children describe how the child is involved in a regular program:

_____

_____

IV. TRANSITION SERVICES HAVE BEEN CONSIDERED AND:

☐ Transition Plan is attached.
☐ Services are stated in IEP.

V. N.C. TESTING PROGRAM: Modification Needed ☐ Yes (See Part 111) ☐ No

VI. IS ADAPTED PHYSICAL EDUCATION REQUIRED? ☐ Yes ☐ No

VII. EXTENDED SCHOOL YEAR (ESY) STATUS:

☐ Is not eligible for ESY
☐ Is eligible for ESY (See goal sheet)
☐ Eligibility is under consideration and will be determine by **(date)**

VIII. IEP COMMITTEE/PRESCHOOL TRANSITION/PLACEMENT COMMITTEE

The following were present and participated in the development and writing of the IEP:

Signatures	Position	Date
_____	LEA Representative	_____
_____	Student's Teacher	_____
_____	Parent	_____

IX. IEP ADDENDUM COMMITTEE/PRESCHOOL TRANSITION/PLACEMENT COMMITTEE

The following were present and participated in the development and writing of the IEP:

Signatures	Position	Date
_____	LEA Representative	_____
_____	Student's Teacher	_____
_____	Parent	_____

X. THIS IEP WAS RECEIVED FOLLOWING REEVALUATION AND WAS FOUND TO BE APPROPRIATE.

Annual review of this IEP will be conducted on or before _____/_____/_____

Signatures	Position	Date
_____	LEA Representative	_____
_____	Student's Teacher	_____
_____	Parent	_____