

A

Letter to Request an Evaluation for Special Education Services

Today's Date (include month, day, and year)

Your Name

Street Address

City, State, Zip Code

Daytime telephone number

Name of Principal or Special Education Administrator

Name of School

Street Address

City, State, Zip Code

Dear (INSERT PRINCIPAL'S OR ADMINISTRATOR'S NAME),

I am writing to request that my (SON/DAUGHTER), (INSERT CHILD'S NAME), be evaluated for special education services. I am worried that (INSERT CHILD'S NAME) is not doing well in school and believe (HE/SHE) may need special services in order to learn. (INSERT CHILD'S NAME) is in the (INSERT GRADE LEVEL) grade at (INSERT SCHOOL'S NAME). (INSERT TEACHER'S NAME) is his/her teacher.

Specifically, I am worried, because (INSERT CHILD'S NAME) does/does not (GIVE A FEW DIRECT EXAMPLES OF YOUR CHILD'S PROBLEMS AT SCHOOL).

We have tried the following to help (INSERT CHILD'S NAME): (IF YOU OR THE SCHOOL HAS DONE ANYTHING EXTRA TO HELP YOUR CHILD, BRIEFLY STATE IT HERE).

A

I understand that I have to give written permission in order for (INSERT CHILD'S NAME) to be evaluated. Before the evaluation begins, I have some questions about the process that I need to have answered (LIST ANY QUESTIONS YOU MAY HAVE). I would be happy to talk with you about (INSERT CHILD'S NAME). You can send me information or call me during the day at (INSERT TELEPHONE NUMBER). Thank you for your prompt attention to my request.

Sincerely,

(INSERT YOUR NAME)
(INCLUDE YOUR SIGNATURE)

cc: (INSERT THE NAME(S) OF PRINCIPAL OR ADMINISTRATOR AND/OR TEACHER)

School District Name

**EVALUATION CONSENT FORM
Attachment to N 1**

TYPE OF ASSESSMENTS: <i>A variety of assessment tools and strategies should be used to gather information that determines the educational needs of this student. [Check yes or no for each assessment.]</i>	RECOMMENDED	
	YES	NO
Assessment in All Areas Related to the Suspected Disability(ies) – describes the student’s performance in any area related to the child’s suspected disability(ies). List recommended assessment(s): _____ _____ _____		
Educational Assessment – includes the history of the student’s educational progress in the general curriculum and includes current information on the student’s performance.		
Observation of the Student – includes the student’s interaction in the student’s classroom environment or in a child’s natural environment or an early intervention program.		
Health Assessment – details any medical problems or constraints that may affect the student’s education.		
Psychological Assessment – describes the student’s learning capacity and learning style in relationship to social/emotional development and skills.		
Home Assessment – details any pertinent family history and home situations that may affect the student’s education and, with written consent, may include a home visit.		

PARENT RESPONSE SECTION

Please indicate your response by checking at least one (1) box and returning a signed copy to the school district. Please keep one copy for your records. Thank you.

I accept the proposed evaluation in full.

I reject the proposed evaluation in full.

I accept the proposed evaluation in part and request that only the listed assessments be completed:

I additionally request the following assessment(s):

assessment(s) listed above:

other assessments: (specify)

Signature of Parent, Guardian, Educational Surrogate Parent, Student 18 and Over*
 *Required signature once a student reaches 18 unless there is a court appointed guardian.

Date

PARENT INPUT

We strongly encourage you to share your knowledge of this student with us. If you choose, please provide a written statement (use back of form) or call the indicated contact person. Thank you.



School District Letterhead

To: *[Name of Parent, Guardian, Educational Surrogate Parent, Student 18 and over]*

Re: *[Name of Student and other identifying information (i.e. DOB, ID#)]*

Subject: **The school district does not intend to act:** *[Check all that apply.]*

- Finding of No Eligibility
- Refusal of Requested Services
- Other: _____
[Please specify.]

Notice Date: *[Date notice is to be mailed.]*

The school district has recently discussed this student with you. We now write to tell you of our intention not to act on a request. We have described our reasons for refusing on page two of this memo.

As you know, special education regulations provide protection to you and your child. You will find specific information about your legal rights in the *Interim Notice of Procedural Safeguards*, including sources that you may contact for help in understanding your rights. You should have received this brochure prior to the initial evaluation. If you would like another copy, please contact the school district staff. You should carefully review this brochure and the enclosed material.

The school district staff is available to speak to you or meet with you about your rights and the school district's refusal to act. We strongly encourage you to call us if you have any questions. Please contact us through the district contact person listed below. Thank you.

District Contact Person: *[Name and Role]*

Contact Information: *[Address, Telephone Number, Fax Number and Email Address (if not on letterhead)]*

Enclosures:

Other: *[specify]*

Re: *[Name of Student and other necessary identifying information]*

Notice Date: *[Date from page 1]*

C

Directions to School Staff:

This notice must be sent to parents in their native language or other mode of communication used by the parent. School districts must ensure that parents understand the content of this notice. (Federal Regulation §300.503)

Describe any refusal to initiate or change the identification, evaluation, educational placement or the provision of special education services by answering the following questions:

- 1. What action is the school district refusing to take?*
- 2. Why is the school district refusing to act?*
- 3. What rejected options were considered and why was each option rejected?*
- 4. What evaluation procedure, test, record or report was used as a basis for the refusal to act?*
- 5. What other factors were relevant to the school district's decision?*
- 6. What next steps, if any, are recommended?*

Narrative Description of School District Refusal To Act

Letter to Request an Independent Evaluation

Today's Date (include month, day, and year)

Your Name

Street Address

City, State, Zip Code

Daytime telephone number

Name of Person to Whom You Are Writing

Title

Street Address

City, State, Zip Code

Dear (name),

My son/daughter, (INSERT CHILD'S NAME), is in the (INSERT CHILD'S GRADE) at (INSERT NAME OF SCHOOL), in (INSERT TEACHER'S NAME) class. (HE/SHE) was evaluated for special education services in (INSERT MONTH/YEAR). I am writing to request an Independent Educational Evaluation at public expense, for the following reasons: (BRIEFLY LIST YOUR REASON(S). BE VERY SPECIFIC.) For example,

"I disagree with the evaluation results because . . ."

"The evaluation should have included . . ."

"Evaluation should have been done in the area of . . ."

I would like this Independent Educational Evaluation to be done as quickly as possible so that we can fully address (INSERT CHILD'S NAME) needs. Please respond as soon as possible and send me copies of the school's guidelines for

this. My daytime telephone number is (INSERT PHONE NUMBER). Thank you.

D

Sincerely,

(INSERT YOUR NAME)
(INCLUDE YOUR SIGNATURE)

cc: (INSERT THE NAME(S) OF YOUR CHILD'S PRINCIPAL
AND/OR YOUR CHILD'S TEACHER)



Individualized Education Program

IEP Dates: from _____ to _____

Student Name: _____ DOB: _____ ID#: _____

Service Delivery

What are the total service delivery needs of this student?

Include services, related services, program modifications and supports (including positive behavioral supports, school personnel and/or parent training/supports). Services should assist the student in reaching IEP goals, to be involved and progress in the general curriculum, to participate in extracurricular/nonacademic activities and to allow the student to participate with nondisabled students while working towards IEP goals.

School District Cycle: 5 day cycle 6 day cycle 10 day cycle other:

A. Consultation (Indirect Services to School Personnel and Parents)

Focus on Goal #	Type of Service	Type of Personnel	Frequency and Duration/Per Cycle	Start Date	End Date

B. Special Education and Related Services in General Education Classroom (Direct Service)

Focus on Goal #	Type of Service	Type of Personnel	Frequency and Duration/Per Cycle	Start Date	End Date

C. Special Education and Related Services in Other Settings (Direct Service)

Focus on Goal #	Type of Service	Type of Personnel	Frequency and Duration/Per Cycle	Start Date	End Date

Use multiple copies of this form as needed.

IEP 5

School District Name:

School District Address:

School District Contact Person/Phone #:

Placement Consent Form – PL1: 6-21 year olds

IEP Dates: from _____ to _____

Student Name:

DOB:

SASID:

Team Recommended Educational Placements	Corresponding Placement
The Team identified that IEP services are provided outside the general education classroom less than 21% of the time (80% inclusion).	<input type="checkbox"/> Full Inclusion Program
The Team identified that IEP services are provided outside the general education classroom at least 21% of the time, but no more than 60% of the time.	<input type="checkbox"/> Partial Inclusion Program
The Team identified that IEP services are provided outside the general education classroom for more than 60% of the time.	<input type="checkbox"/> Substantially Separate Classroom
The Team identified that all IEP services should be provided outside the general education classroom and in a public or private separate school that only serves students with disabilities.	<input type="checkbox"/> Separate Day School <input type="checkbox"/> Public or <input type="checkbox"/> Private
The Team identified that IEP services require a 24-hour special education program.	<input type="checkbox"/> Residential School
The Team has identified a mix of IEP services that are not provided in primarily school-based settings but are in a neutral or community-based setting.	<input type="checkbox"/> Other:

Other Authority Required Placements

Note: These non-educational placements are not determined by the Team and therefore service delivery may be limited.

The placement has been made by a state agency to an institutionalized setting for non-educational reasons.	<input type="checkbox"/> The Department of Youth Services has placed the student in a facility for committed or detained youth.
	<input type="checkbox"/> The Department of Mental Health has placed the student in a hospital psychiatric unit or residential treatment program.
	<input type="checkbox"/> The Department of Public Health has placed the student in the Massachusetts Hospital School. <input type="checkbox"/> Day or <input type="checkbox"/> Residential
	<input type="checkbox"/> The student is incarcerated in the county house of corrections or in a department of corrections facility.
A doctor has determined that the student must be served in a home setting.	<input type="checkbox"/> Home-based Program
A doctor has determined that the student must be served in a hospital setting.	<input type="checkbox"/> Hospital-based Program

Placement Consent Form

Location(s) for Service Provision and Dates:

Parent Options / Responses

It is important that the district knows your decision as soon as possible. Please indicate your response by checking at least one (1) box and returning a signed copy to the district along with your response to the IEP. Thank you.

- I consent to the placement.
- I refuse the placement.
- I request a meeting to discuss the refused placement.

Signature of Parent, Guardian, Educational Surrogate Parent, Student 18 and Over*

Date

*Required signature once a student reaches 18 unless there is a court appointed guardian.



Individualized Education Program

IEP Dates: _____ to _____

Student Name:

DOB:

ID#:

Additional Information

- Include the following transition information: the anticipated graduation date; a statement of interagency responsibilities or needed linkages; the discussion of transfer of rights at least one year before age of majority; and a recommendation for Chapter 688 Referral.
- Document efforts to obtain participation if a parent and if student did not attend meeting or provide input;
- Record other relevant IEP information not previously stated.

ADDED:
 [The IEP] includes appropriate measurable postsecondary goals based upon age appropriate transition assessments related to training, education, employment, and, where appropriate, independent living skills. 614 (d)(1)(A)(i)(VIII)(aa)

IMPLEMENTATION GUIDANCE:
*Beginning not later than the first IEP to be in effect when the student is age 16 see the Transition Planning Chart for guidance related to transition services, goals and courses of study.
 For most students the IEP will be written and implementation begun while the student is age 15.*

Response Section

School Assurance

I certify that the goals in this IEP are those recommended by the Team and that the indicated services will be provided.

Signature and Role of LEA Representative

Date

Parent Options / Responses

It is important that the district knows your decision as soon as possible. Please indicate your response by checking at least one (1) box and returning a signed copy to the district. Thank you.

- I accept the IEP as developed. I reject the IEP as developed.
- I reject the following portions of the IEP with the understanding that any portion(s) that I do not reject will be considered accepted and implemented immediately. Rejected portions are as follows:

- I request a meeting to discuss the rejected IEP or rejected portion(s).

Signature of Parent, Guardian, Educational Surrogate Parent, Student 18 and Over*

Date

**Required signature once a student reaches 18 unless there is a court appointed guardian.*

Parent Comment: I would like to make the following comment(s) but realize any comment(s) made that suggest changes to the proposed IEP will not be implemented unless the IEP is amended.



First Sample Letter
When School Does Not Deliver IEP Services

[Insert Date], 2013

Mr./Ms. [Insert Name of School District Contact Person]
[Insert School District Address]

Re: **[Student's Name]**
Date of Birth: **[Insert Date of Birth]**
Student ID #: **[This is at the top of the IEP]**

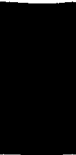
Dear **[Insert Name of School District Contact Person. This is at the top of the IEP.]**:

My **[son/daughter]**, **[Student's Name]** is a special education student at the **[Insert Name of School]**. I am writing to express concern that **[Student's Name]** is not receiving the **[insert name of service]** that is on the IEP. I am enclosing a copy of the Service Delivery Page of **his/her** IEP.

[Student's Name] is not receiving these services. To date, **she/has** has missed **[insert number]** sessions. Please let me know when we can schedule a meeting to discuss this and when the Team will arrange to make up the **[insert number]** sessions **[Student's Name]** has missed. Please note that any letter to me must be translated into my native language, which is **[Spanish, Vietnamese, etc.]**

Sincerely yours,

[Name of Parent or Guardian]



TRANSITION PLANNING FORM (TPF)

Massachusetts requires that beginning when the eligible student is 15 for the IEP developed that year, the school district must plan for the student's need for transition services and the school district must document this discussion annually. This form is to be maintained with the IEP and revisited each year.

Student:	SASID:	Age:
Date form completed:		
Anticipated date of graduation:	Current IEP dates from: _____	to: _____
Anticipated date of 688 referral, if applicable:		

POST-SECONDARY VISION

Write the student's **POST-SECONDARY VISION** in the box below. In collaboration with the family, consider the student's preferences and interests, and the desired outcomes for post-secondary education/ training, employment, and adult living. This section should correspond with the vision statement on IEP 1.

DISABILITY RELATED NEEDS

Write the skills (disability related) that require IEP goals and/or related services in the box below. Consider all skills (disability related) necessary for the student to achieve his/her post-secondary vision.

I

Student: _____

Date form completed: _____

ACTION PLAN

The **ACTION PLAN** should outline how the student can develop self-determination skills and be prepared both academically and functionally to transition to post-school activities in order to achieve his/her post-secondary vision. Indicate how Special Education/General Education, family members, adult service providers or others in the community will help the student develop the necessary skills. **Disability related needs must also be stated on page 1.**

Develop the ACTION PLAN needed to achieve the POST-SECONDARY VISION by outlining the skills the student needs to develop and the courses, training, and activities in which the student will participate. Include information on who will help the student implement specific steps listed below in the Action Plan.

- **Instruction:** Is there a course of study or specific courses needed that will help the student reach his/her post-secondary vision? Consider the learning opportunities or skills that the student may need. This could include specific general education courses and/or special education instruction, career and technical education, and/or preparation for post-secondary outcomes such as vocational training or community college.
- **Employment:** Are there employment opportunities and/or specific skills that will help the student reach his/her post-secondary vision? Consider options such as part-time employment, supported job placement, service learning projects, participation in work experience program, job shadowing, internships, practice in resume writing/ interviewing skills, the use of a one-stop resource center and job specific skills in areas such as customer service, technology, etc.
- **Community Experiences/ Post School Adult Living:** Are there certain types of community and/or adult living experiences that will help the student reach his/her post-secondary vision? Consider options such as participation in community based experiences, learning how to independently access community resources, building social relationships, managing money, understanding health care needs, utilizing transportation options and organizational skills.

Adolescent Autonomy Checklist

Accomplished

Plan to Start

Needs Practice

Can Do Already

Skills at home

Kitchen:

- Operate appliances (cook top, oven, microwave, toaster, dishwasher)
- Use common kitchen tools (can opener, bottle opener, knife, measuring cups and spoons, grater, timer, egg beater, ice cream scoop)
- Help plan and prepare meals
- Follow a recipe
- Put away the leftovers
- Set the table
- Do the dishes
- Familiarity with contents of packaged foods

Laundry

- Put dirty clothes in hamper
- Sort clothes
- Use washer and dryer
- Iron
- Hand wash
- Fold clothes
- Put clothes away

With the Family

- Watch TV news and discuss together
- Help take care of siblings
- Participate in family decisions
- Plan family outing
- Take care of pets

Housekeeping

- Clean room

Developed by the Youth in Transition Project (1984-1987) University of Washington Division of Adolescent Medicine and based on a Model developed by the Children's Rehabilitation Center at the University of Virginia.

Adolescent Autonomy Checklist, Cont'd.

Skills at Home	Can Do Already	Needs Practice	Plan to Start	Accomplished
Housekeeping, Cont'd.				
Make the bed/change the bed				
Choose decorations for room				
Minor repairs (change light bulbs, repair or assemble toys)				
Take out the trash				
Basic sewing/mending skills				
Gardening				
Plant a garden				
Mow/water the lawn				
Weed the garden				
Learn appropriate use of garden tools				
Emergency				
Plan fire exits and emergency procedures				
Know where candles and flashlights are				
Use a fire extinguisher				
Know how to turn water off				
Know community emergency telephone numbers				
Know where extra house key is located				
Unclog the sink or toilet				
Personal Skills				
Use the phone				
Have a house key				
Budget allowance				
Go shopping				
Have privacy in the bathroom				
Manage personal grooming (shampoo, bath, shower)				

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Adolescent Autonomy Checklist, Cont'd.

Skills at Home
Can Do Already
Needs Practice
Plan to Start
Accomplished

Skills at Home	Can Do Already	Needs Practice	Plan to Start	Accomplished
Personal Skills, Cont'd.				
Get a haircut				
Choose appropriate clothes to wear				
Health Care Skills				
Understand health status				
Be aware of existence of medical records, diagnosis information, etc.				
Prepare questions for doctors, nurses, therapists				
Respond to questions from doctors, nurses, therapists				
Know medications and what they're for				
Get a prescription refilled				
Keep a calendar of doctor, dentist appointments				
Know height, weight, birthdate				
Learn how to read a thermometer				
Know health emergency telephone numbers				
Know medical coverage numbers				
Obtain sex education materials/birth control if indicated				
Discuss role in health maintenance				
Have genetic counseling if appropriate				
Discuss drugs and alcohol with family				
Make contact with appropriate community advocacy organization				
Take care of own menstrual needs and keep a record of monthly periods				
Community Skills				
Get around the city (pedestrian skills, asking directions)				

Adolescent Autonomy Checklist, Cont'd.

Skills At Home **Can Do Already** **Needs Practice** **Plan to Start** **Accomplished**

Community Skills, Cont'd.				
Get around the city (pedestrian skills, asking directions)				
Use public transportation (taxi, bus, etc.)				
Locate bathroom in unfamiliar building (i.e. know how to ask)				
Know about neighborhood stores and services				
Use a pay phone				
Use a phone book				
Open a bank account				
Get a library card				
Get a picture ID				
Get a Social Security Card				
Use Post Office				
Volunteer for community services				
Leisure Time Skills				
Help plan a party				
Invite a friend over				
Subscribe to a magazine				
Read a book				
Plan a TV viewing schedule				
Go for a walk				
Join the Scouts, YMCA/YWCA, 4-H Club				
Go to a recreation center				
Go to camp				
Attend school functions (plays, dances, concerts, sports)				
Go to Church				
Keep a calendar of events				
Participate in a sport				

Adolescent Autonomy Checklist, Cont'd.

Skills At Home
Can Do Already
Needs Practice
Plan to Start
Accomplished

Skills For The Future- Education				
Meet with school Guidance Counselor				
Check future educational options				
Vocational/Technical Options				
Contact school Guidance or DVR Counselor				
Check on local workshops/job opportunities				
Find out about apprentice programs				
Get information from community colleges				
Learn how to apply for a job				
Vocational/Technical Options, Cont'd.				
Check on local workshops/job opportunities				
Find out about apprentice programs				
Get information from community colleges				
Learn how to apply for a job				
Living Arrangements				
Be aware of federal housing regulations for the disabled				
Explore group homes and tenant support apartment living programs				
Find out about financial assistance programs				
Learn how to manage money and budget household expenses				
Understand leases				
Know the responsibilities of a tenant & landlord				
Know how to fill out an application				
Check for wheelchair accessibility if needed				
Look into transportation				

Know about Services electricity, phone, water

Delegation of Educational Authority

I, [name of student], having reached the age of majority, hereby exercise my right pursuant to 603 CMR 28.07(5)(c) to delegate continued decision-making to [or share decision-making with] my [insert mother, father, legal guardian, etc., [insert name of parent], regarding my special education services. This shall include the right to sign my Individual Education Plan (IEP) on my behalf and to agree to any educational placement. I understand that I may revoke this delegation in writing at any time.

[name of student]

Date

(Please Print)

Witness

Date

(Please Print)

[Please note you *must* sign this form in the presence of a school official, such as the Team Leader or the Special Education Director.]