

RE-EVALUATION REPORT (PAGE 2 OF 2)

Confidential Document

Name: _____ Date of Birth: _____

IV. Results of Re-evaluation:

A. Is there sufficient data to determine that the child/student continues to have the existing disability?

☐ YES ☐ NO

B. Is there sufficient data to determine the child/student's present levels of performance and educational needs?

☐ YES ☐ NO

Reading: _____ Math: _____ Language: _____

Present Levels of Performance (Grade)

C. Is there sufficient data to determine whether the child/student continues to need special education and related services?

☐ YES ☐ NO

D. Is there sufficient data to determine whether any additional or modifications to the special education and related services are needed to enable the child/student to meet the measurable annual goals set out in the Individualized Education Program (IEP) of the child/student and to participate, as appropriate, in the general curriculum?

☐ YES ☐ NO

E. Follow-up Needed, If any:

1. ☐ Additional Data Needed/Provided: (Specify) _____

2. ☐ Reconvene the IEP Team after additional data collect **This meeting MUST be scheduled so as not to exceed the due date for this re-evaluation.**

3. ☐ Other: (Specify) _____

F. Disability: _____ Subcategory: _____

G. Related Services Needed: _____

H. Complete Review/Revision Block on back page of IEP.

I. Is there a change in placement as a result of this reevaluation?

☐ YES ☐ NO

If yes, give parent form 10. Notice sent _____ Verified _____

J. Is there a change in identification as a result of this reevaluation?

☐ YES ☐ NO

If yes, give parent form 11. Notice sent _____ Verified _____

We have reviewed the information and agree with the findings in this report.

IEP Committee/Signatures

Position

Date

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Copies Must Be Provided to Teacher(s), Parent(s), and Diagnostic Services.

PARENT INVITATION RESPONSE FORM

(District Identification/Notice of Committee Meeting)

NAME OF CHILD: _____

Date Sent: _____ Purpose of Meeting: _____

Date of Scheduled Meeting: _____ Time of Scheduled Meeting: _____

Location of Scheduled Meeting: _____

Please verify your response below and return to the person listed at the bottom of the page within two (2) days.

☐ I will attend the meeting at the scheduled time.

☐ I want to come, but I cannot attend the meeting at the scheduled time. Please contact me at

_____ to make other arrangements. I am available for the following:

(Telephone Number)

DATE(S)

TIME(S)

☐ I will not be able to attend the meeting in person, but would like to participate via telephone. Please contact me at

_____ at the scheduled meeting time.

(Telephone Number)

☐ I do not wish to participate in the meeting. Please conduct the meeting without me being present, but contact me following the meeting.

Parent Signature _____

Date _____

Please return this form to:

NAME AND TITLE: _____

SCHOOL: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

Method of verification _____ Date verified _____ By Whom _____

NOTICE OF IEP COMMITTEE'S DECISION FOR REEVALUATION

(No Additional Assessment Needed)

School District: _____

Date Given: _____

Dear Parent:

The IEP Committee has reviewed existing evaluation data concerning your child _____ and determined that no additional assessment data is needed to determine your child's continued eligibility to receive special education and related services or to determine your child's educational needs.

The committee's decision was based on the following reason(s):

- ☐ Previous disability category accurately reflects your child's disability.
- ☐ Information provided by the parent supports the continued need for special education and, if appropriate, related services.
- ☐ Current curriculum-based assessments and observations support the current disability category and identify the education needs of your child.
- ☐ Information contained in the current IEP indicates a continued need for special education and, if appropriate, related services.

However, you, as the parent, have the right to request an assessment if you believe that additional testing is needed to determine your child's disability or educational needs. In order to document your decision, please check one of the choices below and provide your signature as indicated below.

- ☐ I understand that additional testing of my child is not necessary at this time to determine my child's disability or educational needs and I agree with this recommendation. I have received a copy of the Procedural Safeguards documents, which includes the rights available to me and my child, with this notice. An explanation of these rights has been provided to me. My signature provided below indicates I am in agreement with this recommendation.
- ☐ I do not agree with the decision that no additional assessment is needed to determine my child's disability or educational needs as documented in the manner described above, and I request that my child be reevaluated. I have received a copy of the Procedural Safeguards document, which includes the rights available to me and my child, with this notice. An explanation of these rights has been provided to me. My signature provided below is consent for additional assessment to be conducted by qualified school personnel to determine my child's particular disability category and my child's continued need for special education and related services. I understand that my written consent for this activity is voluntary and may be revoked at any time.

Parent Signature

Date

If you have any questions, please call _____ at _____
(Name/Title) (Phone Number)

Please return this signed notice to:

(Name/Title)

(Address)

NOTICE OF IEP COMMITTEE'S DECISION FOR REEVALUATION

(Additional Testing Requested)

School District: _____

Date Given: _____

Dear Parent:

The IEP Committee has reviewed existing evaluation data concerning your child _____ and determined that additional assessment data is needed to determine your child's continued eligibility to receive special education and related services or to determine your child's educational needs.

The committee's decision was based on the following reason(s):

- ☐ Previous disability category may not accurately reflect your child's disability.
- ☐ Reevaluation is necessary to determine your child's appropriate disability category.
- ☐ Evaluation is needed to determine your child's eligibility for Language/Speech services.
- ☐ Current curriculum-based assessments and observations indicate the need for additional assessment to determine your child's disability and education needs.
- ☐ The current IEP indicates a need for a reevaluation to determine your child's present level of performance, special education services and, if appropriate, the related services needs of your child.

Although the committee decided that additional assessment is needed to determine your child's disability and educational needs, your permission is necessary before any assessment can be conducted. Without your permission, district personnel cannot ensure a free appropriate public education is provided for your child. A copy of the procedural safeguards, which include the rights available to you and your child, are enclosed with this notice. An explanation of these rights has been provided to you. If you are in agreement with the committee's decision, please provide your consent for additional testing by signing the statement below.

I understand that the committee determined that additional assessment is necessary to determine my child's disability and educational needs. I have received written prior notice of the committee's decision and Procedural Safeguards. My rights and those of my child have been fully explained to me. I agree with the decision of the committee and, I hereby give my consent for additional assessment to be conducted by qualified school personnel to determine my child's particular disability category, my child's continued need for special education and, as needed, related services. I understand that my written consent for this activity is voluntary and may be revoked at any time.

Parent Signature

Date

If you have any questions, please call _____ at _____
(Name/Title) (Phone Number)

Please return this signed notice to:

(Name/Title)

(Address)

NOTICE OF COMMITTEE MEETING**(Proposed Action to Initiate the Development or Review/Revision of IEP;
Determine Behavior Plan/Interventions & Manifestation Review; Reevaluation)**

School District _____

DATE: _____ ☐ MAILED ☐ SENT ☐ GIVEN

SCHOOL: _____ NAME OF STUDENT: _____

Dear Parent:

You are invited to a meeting to discuss your child's education services and program. Any changes in your child's educational placement will also be discussed. Such services and changes in your child's program will be determined by the IEP Committee. You are considered a committee member; therefore, your participation in this meeting is needed.

We encourage you to attend this meeting as decisions will be made regarding your child's educational program. Your involvement is an important part of your child's education and your participation in this meeting is needed. The meeting will be held as follows:

TIME: _____ DATE: _____

LOCATION: _____

The purpose of the meeting is to:

- ☐ Develop a temporary IEP for your child.
- ☐ *Develop the IEP for your child, including the determination of your child's special education and related service needs
- ☐ **Discuss transition services
- ☐ Discuss options for exiting high school
- ☐ Determine your child's placement for receiving special education services
- ☐ Review and, as necessary, revise your child's IEP
- ☐ Review and, as necessary, revise your child's IEP based on the hearing officer's order to place in an interim alternate setting
- ☐ Review your child's placement for services
- ☐ Discuss reevaluation to determine whether your child continues to have a disability, including the need for special education and related services and whether your child's current disability category continues to be appropriate
- ☐ Determine placement based on disciplinary action by school authorities
- ☐ Develop and/or review a behavior plan for your child
- ☐ Develop and/or review behavioral interventions
- ☐ Determine if your child's behavior(s) is related to your child's disability
- ☐ Determine if criteria for Extended School Year (ESY) services are met.
- ☐ OTHER (Please specify): _____

Reason(s) for such action(s) proposed include requirement to:

- ☐ Determine appropriate special education and, as necessary, related services for your child
- ☐ Develop an IEP for your child so that special education and, as necessary, related services may be initiated
- ☐ Determine your child's placement to receive appropriate services
- ☐ Review and, as necessary, revise your child's IEP to ensure appropriate services are provided
- ☐ If your child is at least 14, discuss and develop/revise transition services which are a coordinated set of activities based on your child's needs that promote movement from school to post-school activities
- ☐ If your child is at least 16, discuss services from other agencies that may be available to assist with transition services
- ☐ Review program options and determine the appropriate placement for your child to receive services and, as appropriate, change your child's placement to an appropriate setting
- ☐ Review the placement of your child based on his/her educational needs
- ☐ Conduct a reevaluation due to three year mandate
- ☐ Conduct a reevaluation as requested by the parent(s) or teacher(s) or as conditions warrant
- ☐ Determine the interim alternate setting for placement based on disciplinary action by school authorities
- ☐ Change your child's placement to another setting due to disciplinary action(s)
- ☐ Develop a behavior plan or review an existing plan and revise the plan, if necessary
- ☐ Develop behavior interventions or review existing interventions and revise them, if necessary
- ☐ Determine if your child's behavior(s) is related to your child's disability
- ☐ Determine if criteria for Extended School Year (ESY) services are met.
- ☐ OTHER (Please specify): _____

Options considered before convening this meeting:

- | | | |
|---|---|---|
| <input type="checkbox"/> Regular education without services | <input type="checkbox"/> Tutoring | <input type="checkbox"/> Alternate Program |
| <input type="checkbox"/> Change in teaching methodology | <input type="checkbox"/> Schedule change | <input type="checkbox"/> Current placement with supplementary aids and services, as appropriate |
| <input type="checkbox"/> Behavior interventions | <input type="checkbox"/> Counseling | <input type="checkbox"/> Rules and requirements mandate need for meeting |
| <input type="checkbox"/> Bilingual/ESL services | <input type="checkbox"/> Remedial Program | |
| <input type="checkbox"/> OTHER (Please specify): _____ | | |

NOTICE OF COMMITTEE MEETING – Page 2

(Proposed Action to Initiate the Development or Review/Revision of IEP; Determine Behavior Plan/Interventions & Manifestation Review; Change in Placement)

The options considered were rejected by school personnel due to:

- | | |
|---|---|
| <input type="checkbox"/> Continued academic difficulty by your child | <input type="checkbox"/> Disciplinary action(s) requirement that placement be changed in accordance with district policies |
| <input type="checkbox"/> Interventions were unsuccessful | <input type="checkbox"/> No rejection of options; meeting must be held due to regulations and the need to review and, if necessary, revise your child's IEP |
| <input type="checkbox"/> Educational needs cannot be met in current placement | |

The following persons have been asked to attend this meeting (Name):

Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Special education teacher _____	Psychologist _____
Assessment personnel _____	Speech/Language pathologist _____	Diagnostic personnel _____
School administrator _____	Behavior Specialist _____	Occupational Therapist _____
Regular education teacher _____	Vocational representative _____	Physical Therapist _____
OTHER (Please specify): _____		

The following evaluation procedures, tests, records or reports will be reviewed and discussed:

- | | | |
|---|---|--|
| <input type="checkbox"/> Vision/hearing screening | <input type="checkbox"/> Personality assessment | <input type="checkbox"/> Progress reports |
| <input type="checkbox"/> Classroom observations | <input type="checkbox"/> Curriculum-based assessment | <input type="checkbox"/> Current IEP |
| <input type="checkbox"/> Academic achievement | <input type="checkbox"/> Vocational assessment | <input type="checkbox"/> Disciplinary action(s) by school authorities |
| <input type="checkbox"/> Speech/language skills | <input type="checkbox"/> Assistive technology assessment | <input type="checkbox"/> Requirements for high school graduation |
| <input type="checkbox"/> Gross/fine motor skills | <input type="checkbox"/> Self-help/adaptive behavior | <input type="checkbox"/> Program placement options |
| <input type="checkbox"/> Orofacial functioning | <input type="checkbox"/> Functional behavioral assessment | <input type="checkbox"/> Criteria for extended school year |
| <input type="checkbox"/> Visual/auditory skills | <input type="checkbox"/> Cognitive functioning | <input type="checkbox"/> Preliminary goals & objectives for services |
| <input type="checkbox"/> School and/or home behaviors | <input type="checkbox"/> Hearing officer's decision | <input type="checkbox"/> State and/or district assessment program criteria |
| <input type="checkbox"/> Audiological evaluations | <input type="checkbox"/> Parental input | |
| <input type="checkbox"/> Functional vision assessment | <input type="checkbox"/> OTHER (Please specify): _____ | |

*Regulations require that written parental permission be obtained prior to the initial provision of special education and, as necessary, related services outlined on your child's IEP. After we agree on your child's initial IEP, we will want you to give us permission in writing for placement. No special education and related services will be provided to your child without your written permission.

**Your child has been invited to the meeting since one purpose of the meeting is to discuss and plan transition services. Your child's attendance is needed so we can discuss his/her preferences and interests in relation to transition services. If your child is at least 16 years old, staff from other agencies who may be able to provide appropriate services have also been invited to attend. The agencies they represent are shown below:

- | | |
|--|--|
| <input type="checkbox"/> Department of Vocational Rehabilitation | <input type="checkbox"/> Department of Mental Health |
| <input type="checkbox"/> OTHER (Please specify): _____ | |

You may bring any individuals you believe would be of help to you due to their knowledge or expertise regarding your child.

You may contact me or any of the following resources to help you understand the federal and State regulations for educating children with disabilities and parental rights granted by those regulations:

Mississippi Department of Education 1-601-359-3498
Mississippi Protection and Advocacy, Inc. 1-800-772-4057
Parent Partners 1-800-366-5707
Project EMPOWER 1-800-337-4852

Other Resources: _____

Both State and federal regulations concerning the education of children with disabilities include many parental rights and responsibilities. A copy of the procedural safeguards which include the rights available to you and your child are enclosed with this notice.

Please keep these pages for your records and complete the attached Response Form and return it to me by the noted timeframe in order to finalize the plans for the meeting. Your input and opinions concerning your child's services and placement are very important.

Sincerely,

Name and Title

Telephone Number