
Present Levels of Academic and Functional Performance
Student Strengths and Parental Concerns

Health/Physical/Motor

Social/Emotional

Academic Performance

Communication

Transition Services

Statement of Needed Transition Services (ages 14-21, or younger if appropriate)
Tri-County Interlocal 607

























Name: Legal Full Name (last,first)

Date:

District:

**Desired
post
school
outcome
(Goal):**

Year in school:

Present Levels and Transition Needs	Activities and Strategies	Time Line	Provider
Instruction:  	  	  	
Community Participation  	  	  	
Employment/Career Goal:  	  	  	
Adult/Daily Living:  	  	  	

Recreation and Leisure:			
Transition Related Services:			
Functional/Vocational Evaluation:			

Transition: Voc. Rehabilitation and Other Agencies

Transition: Statement of Trans. Service Needs

Goals/Benchmarks

Goal No. _____
Goal Text:

State Standard:

Baseline:

Evaluation Procedure:

Benchmark # 1 Text:

Benchmark # 2 Text:

Benchmark # 3 Text:

Benchmark # 4 Text:

Benchmark # 5 Text:

Benchmark # 6 Text:

Benchmark # 7 Text:

Anticipated Services to be Provided

Special Education Services

Related Services

Supplementary Aids and Services

Program Modifications and Staff Training

Supports for School Personnel

Participation with Non-Disabled Students in the Regular Education Environment

Potential Harmful Effects

Participation in District-wide Assessments

Participation in State Assessments

Extended School Term

Behavior Intervention Plan

Assistive Technology Plan

Team Considerations

Special Considerations

Notification of Transfer of Rights

The student has been informed that at age 18 all rights afforded parents under special education law will transfer to the student unless he/she has been legally adjudicated to be an incapacitated person or a child in care. This means that in the absence of court directive, the student will become the educational decision maker.

Notice provided to: _____ Parents (Date____) _____ Student (Date____)

CHANGE to: _____ Parents (Date____) _____ Student (Date____)

Progress Report

Parent Release of Information

Student Name: Legal Full Name (first,last) Birthdate Birthdate

Permission is given for the Agency Name LEA to share appropriate information concerning the above listed student with the Kansas Health Policy Authority so the LEA, can, if applicable, seek reimbursement for any health-related services that are claimable under the Title XIX Medicaid Program or the Title XXI State Child Health Insurance Program.

In conjunction with the above, I understand that the LEA may also need to obtain a "Physician's Prescription" for some/all of the health-related services that is provided to the student. In this regard, I hereby give permission for the LEA, if applicable, to share portions of the student's Individual Education Plan (IEP) with a qualified health care professional in order to obtain such "Physician's Prescriptions".

Physicians Name: _____

Contact Information: _____

I understand that the LEA is required to provide certain health-related services to any student who has an IEP at no additional cost to the student's parent (s)/guardian(s). I also understand that my signature- or failure to sign this form- will not affect whether such services are provided to the student.

I understand all of the statements set forth above * and I hereby grant all of the above * referenced permissions for the period from July 1, 2008 through June 30, 2010.

PARENT(S)/GUARDIAN(S)SIGNATURE(S) _____
DATE ____/____/____

PHYSICIAN AUTHORIZATION

Dear Health Care Provider:

As specified in the student's Individual Education Plan (IEP), the student qualifies to receive one or more of the following services during the time period that is specified in that IEP.

- | | | |
|------------------|-------------------------|-------------------------|
| Audiology | Occupational Therapy | Physical Therapy |
| Nursing Services | Speech/Language Therapy | Attendant Care Services |

If/as appropriate, the LEA may seek reimbursement from the Kansas Health Policy Authority for some/all of the above-listed services. In order to do that, however, the LEA must obtain the signature of a qualified health care provider.

