

K-12 NONPUBLIC STUDENT SPECIAL EDUCATION SERVICE PLAN

Berrien Regional Education Service Agency, Berrien Springs, Michigan

STUDENT INFORMATION

Student Name: _____ Date: _____ Page 1 of _____

Birthdate _____ Age _____ School _____

Native Language of Family: _____ Native Language of Student: _____

INVITATION

A written invitation/notice, including purpose of meeting, role of participants and procedural safeguards was sent to parent/guardian/student:

By _____ Date _____

Additionally, the following efforts were made to arrange a mutually agreeable time and place of meeting:

By _____ Method of Contact _____ Date _____

IEP MEETING PARTICIPANTS AND ATTENDANCE

Signatures of the following individuals indicate participation in the service plan meeting:

Parent(s)/ Guardian(s)/ Surrogate(s): _____
 Special Education Provider: _____

General Education: _____

Student: _____ MET Representative: _____

Nonpublic School Rep: _____ Public School District Rep: _____

Other: _____ Other: _____

STUDENT PROFILE AND ELIGIBILITY

In determining both eligibility and need for services, the participants considered each of the following:

Student Strengths: _____

Parent Concerns: _____

Based upon 1) this student's current functioning, 2) the most recent evaluation findings dated ____/____/____ and 3) any additional assessment information, the team members determine that this student has a disability that requires special education programs/services?

No (Explain): _____

Yes (Check eligibility below):

- | | | |
|---------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Cognitive Impairment R340.1705 | <input type="checkbox"/> Other Health Impairment R340.1709a | <input type="checkbox"/> Autism Spectrum Disorder R340.1715 |
| <input type="checkbox"/> Emotional Impairment R340.1706 | <input type="checkbox"/> Speech & Language Impairment R340.1710 | <input type="checkbox"/> Traumatic Brain Injury R340.1716 |
| <input type="checkbox"/> Hearing Impairment R340.1707 | <input type="checkbox"/> Early Childhood Developmental Delay R340.1711 | <input type="checkbox"/> Deaf-Blindness R340.1717 |
| <input type="checkbox"/> Visual Impairment R340.1708 | <input type="checkbox"/> Specific Learning Disability R340.1713 | |
| <input type="checkbox"/> Physical Impairment R340.1709 | <input type="checkbox"/> Severe Multiple Impairment R340.1714 | |

STATEMENT OF NEED

ANNUAL GOALS

See attached Goal page(s)

ANCILLARY SERVICES

Name of Service Rule #	Amount of Time/Frequency (Min/Hr) per (day/week/month)	Provider Name (Registry Purposes Only)	Location
R340. _____			
R340. _____			
R340. _____			
R340. _____			

SPECIAL TRANSPORTATION

Transportation: Does the student require special transportation?

- No, general transportation is sufficient to meet this student's needs, or no transportation is required.
- Yes, special transportation within the boundaries of the local public district is required due to the following (Check all that apply and list requirements)
 - The student requires transportation because the ancillary services are provided outside of the nonpublic school
 - The medical, health, developmental and/or behavioral needs of this student necessitates special transportation (specify) _____

OTHER CONSIDERATIONS

List any comments and/or describe provisions not documented elsewhere in this plan:

OPERATING DISTRICT COMMITMENT

The operating district:

- Agrees** with the recommendation of the service planning team.
- Assigns** responsibility for implementation to: _____ Start Date: _____ End Date: _____

Signed: _____
Operating District Superintendent or Designee

Date: _____
(mo/day/yr)

PARENT/GUARDIAN ACKNOWLEDGEMENT

For all students attending a nonpublic school located within the boundaries of this district, the district will provide **special education evaluations and ancillary services** on an equitable basis with public district programs.

- **For students who are residents of this district**, the district will provide a free and appropriate public education (FAPE) to the student if the student enrolls in the public district.
- **For non-resident students of this district**, neither this district nor your district of residence (if different) is required to provide a free and appropriate education (FAPE) if you choose to keep you child enrolled in the nonpublic school program in this district.

For the purpose of billing the state for any Medicaid-related services on this IEP, the resident district and RESA request your permission to release minimal student information to the state. Billing does not affect or limit any family Medicaid benefits and consent may be revoked at any time.

- I/We **agree** to allow the school to release information to the state to bill the state for Medicaid-related services on this IEP.
- I/We **do not agree** to allow the school to release information to the state to bill the state for Medicaid-related services on this IEP.

I as the Parent/Guardian/Surrogate/Student: (check one)

- Consent** to the service plan and its implementation.
- Do not agree** with the service plan and:
 - Plan to enroll my child in his/her district of residence or other district.
 - Plan to keep my child enrolled in this nonpublic school and decline special education ancillary services at this time.
 - Will allow this plan to be implemented.

Signed: _____
Parent/Guardian/Surrogate/Student

Date: _____
(mo/day/yr)

The Procedural Safeguards Notice you received when the district requested your consent for the initial evaluation describes protections under the IDEA. The Procedural Safeguards Notice is also available at www.michigan.gov/documents/mde/May09-ProceduralSafeguardsNotice_278611_7.pdf.