

SEDGWICK COUNTY AREA EDUCATIONAL SERVICES INTERLOCAL COOPERATIVE #618

IEP AMENDMENT FORM

Date of Annual IEP: _____

Date of IEP Revision: _____

Student Name: _____

DOB: _____ **Grade:** _____

Responsible Bldg: _____

Attendance Bldg: _____

Primary Provider: _____

Is this a Move-In IEP Meeting? Yes No

(Check all areas of IEP which have been amended at this IEP meeting)

- Health/Physical
- Social/Emotional
- General Intelligence
- Academic Performance
- Communication
- Desired Post School Outcomes & Present Levels
- Transition: Instructional
- Transition: Related Services
- Transition: Community Experiences
- Employment & Other Post-School/Adult Living Outcomes
- Transition: Current and Future Daily Living Skills
- Transition: Functional Vocational Evaluation
- Vocational Rehabilitation and Other Agencies
- Agency Collaboration & Responsibilities
- Graduation Plan/Transition Service Needs
- Goals: _____ Goal #(s) _____
 Added Deleted Changed
- Bench/Obj: _____ Goal #(s) _____ B/O#(s) _____
 Added Deleted Changed
- Special Education Services
- Related Services
- Supplementary Aids and Services
- Program Modifications
- Supports for School Personnel
- Educational Placement
- Special Considerations

- Participation in District-wide Assessments
- Participation in State Assessments
- Behavior Intervention Plan
 - Attached Plan
 - Added Deleted Changed
 - Addressed in Goals/Bench/Obj (Indicate changes in Goals/Bench/Obj section)
 - Added Deleted Changed
 - Addressed in other areas (Name Area) _____
 - Added Deleted Changed
- Assistive Technology Plan
- Participation in Extended School Term
- Exceptionality
- Special Transportation Needed
- IEP Team Checklist
- Questions Section of IEP

Anticipated Services Chart

Line number(s) on Anticipated Services Chart that are Changed

- Provider: / / / / /
- Service: / / / / /
- Setting: / / / / /
- Minutes: / / / / /
- Days: / / / / /
- Weeks: / / / / /
- Att. Bldg. #, LEA: / / / / /
- Begin Date: / / / / /
- End Date: / / / / /

Participants in the IEP Team Meeting	Position	Date	Participants in the IEP Team Meeting	Position	Date

If any mandatory IEP members were legally excused from the IEP team meeting, please document the justification for their absence:

Name of Person(s) and Address(s) to receive Sent Original IEP: Name(s): _____

Address(s): _____ **City(s):** _____ **State(s):** _____ **Zip(s):** _____

Medicaid Information Release Form (Only for move-in students who are Medicaid Eligible)

Authorization is hereby granted for the Sedgwick County Area Educational Services Interlocal Cooperative #618 to the release of all necessary medical/educational records and information to Medicaid and/or their representatives for the purpose of processing the claims and the direct payment of insurance/Medicaid reimbursement to the Cooperative. I understand that this permission is not necessary in order for my child to receive services.

Parent or Guardian: _____ Printed Name: _____ Date: _____