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| **DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA****DESERT/MOUNTAIN CHARTER SPECIAL EDUCATION LOCAL PLAN AREA**17800 HIGHWAY 18 • APPLE VALLEY, CA 92307 (760) 552-6700 • (760) 242-5363 FAX**Triennial Assessment Determination Form**(To be completed prior to the Triennial due date to determine what assessments, if any, need to be conducted.) |
| **STUDENT Information** |
| Student Name: |  | Date of Birth: |  | Grade: |  |
| School Site: |  | District of Attendance: |  | District of Residence: |  |
| **Triennial Due Date:** |  |
| Parent/Guardian/Surrogate contacted on: *(Date)* |  |
| Method of Contact: | [ ]  Phone Conference | [ ]  IEP Meeting | [ ]  Other Meeting | [ ]  Written Conference |
|  |  |  |  |  |
| **As part of determining the need for reassessment the district has completed all of the following steps:** |
|  | 1. | Existing assessment data has been reviewed, including assessments provided by the parents |
|  | 2. | Current classroom-based assessments have been reviewed |
|  | 3. | Teacher and related service provider(s) observations have been reviewed |
|  | 4. | Parent/Guardian input has been reviewed and considered |
| **Based upon a review of the information referenced above, the district, in collaboration with parent, has determined that**  | **[ ]  Yes** | **[ ]  No** |
| **additional assessment is needed.** |  |  |
| **If “*YES*,” it is recommended that assessment be completed in the following areas (D/M 66 must be completed): *(Check all that apply)*** |
| [ ]  | Academic Assessment | [ ]  Cognitive Data | [ ]  Social/Emotional | [ ]  Behavioral Data | [ ]  Motor Skills Data | [ ]  Health Data |
| [ ]  | Language/Speech | [ ]  Occupational Therapy | [ ]  Physical Therapy | [ ]  Adapted P.E. | [ ]  Postsecondary Transition |
| [ ]  | Vision and Hearing: *(Check all that apply below)* |  |
|  | *[ ]  Vision and Hearing assessment dated* |  | *to be used for this evaluation period (within one year)* |
|  | *[ ]  Parent to provide privately-obtained Vision or Hearing assessment* |
|  | *[ ]  Parent declined Vision and Hearing screening by the district* |
| [ ]  | Alternate means of assessment: *(Describe, if applicable)* |  |
|  |  |
| [ ]  | Other: |  |
|  |  |
| **Additional assessment data is needed to determine:** |
|  | 1. | Whether the student has a particular category of disability and/or continues to meet the eligibility criteria as a child with a disability |
|  | 2. | The present level of performance of the student and the student’s educational needs |
|  | 3. | Whether the student continues to need special education and related services |
|  | 4. | Whether any additions or modifications to special education and related services are needed to enable the student to meet the annual |
|  |  | goals included in the student’s IEP and to participate, as appropriate, in the general curriculum |
|  |  |  |
| **If “*NO*,” state reason(s) it was determined that further assessment data was not needed:**  |
|  |  |  |
| **NOTE: PARENTS MAY REQUEST FULL ASSESSMENT TO DETERMINE ELIGIBLITY/INELIGIBILITY FOR SERVICES AT****ANY TIME, OR MAY AGREE TO FOCUSED DATA COLLECTION IN SPECIFIC AREAS.** |
| [ ]  | I have been advised of and given a copy of the Special Education Procedural Safeguards/Parent Rights |
| [ ]  | I agree and understand that assessment is needed in the areas marked above (Assessment Plan is required, form D/M 66) |
| [ ]  | I agree and understand that no new assessment is needed |
|  |  |  |  |  |
| Parent/Guardian/Surrogate | Date |  | Parent/Guardian/Surrogate | Date |
|  |  |  |  |  |
| LEA Representative | Date |  | Student | Date |
|  |  |  |  |  |
| Special Education Teacher | Date |  | General Education Teacher | Date |
|  |  |  |  |  |
| School Psychologist | Date |  | Speech-Language Pathologist | Date |
|  |  |  |  |  |
| Other/Title | Date |  | Other/Title | Date |