Offer of FAPE
SERVICES

Name _____ **IEP Date:**
The service options that were considered by the IEP team (list all): **(In selecting LRE, describe the consideration given to any potential harmful effect on the child or on the quality of services that he or she needs)**

Supplementary Aids, Services & Other Supports for school personnel, or for student, or on behalf of the student

Aids, Services, Program Accommodations/Modifications, and/or Supports	Start Date	End Date	Frequency	Duration	Location

Transportation Special Ed ☐No☐Yes

SPECIAL EDUCATION and RELATED SERVICES

Service: _____

Start Date: _____ **End Date:** _____

Provider: _____☐Ind☐Grp☐Sec Transition

Duration/Freq: _____ **min** _____ **Totaling:** _____ **min served** _____

Location: _____

Comments: _____

Service: _____

Start Date: _____ **End Date:** _____

Provider: _____☐Ind☐Grp☐Sec Transition

Duration/Freq: _____ **min** _____ **Totaling:** _____ **min served** _____

Location: _____

Comments: _____

EXTENDED SCHOOL YEAR (ESY)

☐Yes☐No

Service: _____
Start Date: _____ **End Date:** _____

Provider: _____☐Ind☐Grp☐Sec Transition

Duration/Freq: _____**min** _____ **Totaling:** _____**min served** _____

Location: _____

Comments: _____

Programs and services will be provided according to when student is in attendance and consistent with the district of service calendar and scheduled services, excluding holidays, vacations, and non-instructional days unless otherwise specified.