APPENDIX C

Assessment Plan

Student Name ______________________ Date of Birth ___/___/___ Date ___/___/_____

☐Initial ☐Annual ☐Triennial ☐Transition ☐Interim ☐Other____

To parent/guardian of ________________________ Assessment Plan Date ___/___/_____

District ___________________________________ School ____

Grade _____________________________________ Date of Birth ___/___/_______

Native Language ____________________________ English proficiency/CELDT Level __________________________

The student has been referred and/or recommended for an assessment by the following individual(s):

☐ Parent ______ ☐ Nurse ______ ☐ Teacher ______ ☐ Special Ed Teacher ______ ☐ Other ______

This notice is to inform the parent(s) regarding the school district's proposal to initiate or change the: ☐Identification ☐Evaluation of the above named student:

This prior written notice includes a description of the proposed evaluation, an explanation of why the district proposed to take this action, a description of any other options that were considered and the reasons why those options were rejected, and other factors that are relevant in this proposal. Your written permission must be given before we assess your child to determine initial or continued eligibility for special education services. You have the right to be familiar with the assessment procedures and type of tests that may be given to your child. After the assessment is completed, you will be notified in writing of a meeting to discuss the results of the evaluation. If your child is found eligible for special education services, a full range of program options will be discussed.

Description of the proposed assessment:

The assessment will be conducted by qualified staff, and when appropriate, interpreters of the individual's primary language may be used. Tests conducted pursuant to these assessments may include, but are not limited to classroom observations, rating scales, one-on-one testing or some other types or combination of tests. No single procedure may be used as the sole criterion for determining appropriate educational program. Following the completion of the assessment, at the IEP meeting; you will receive a copy of the assessment findings. The results of this assessment may be a recommendation for special education services or maintenance or change of the current special education service(s). A student will not be placed in special education without consent of the parent or guardian. All information and assessment results are confidential.

Reason(s) for proposed assessment:

Description of other options considered and reasons for rejecting them:

Other factors relevant to the proposal:

Description of evaluation procedures, tests, records, or reports used in deciding to propose this assessment:

The district proposes to assess your child to determine his/her eligibility for special education services or continued eligibility and present levels of academic performance and functional achievement. Your child will be assessed in all areas of suspected disability as needed.* To meet your child's individual education needs, this assessment will consist of an evaluation in only the areas checked by the local educational agency (LEA)/district. *Tests and procedures conducted pursuant to these assessments may include, but are not limited to, classroom observations, rating scales, interviews, record review, one-on-one testing, or some other types or combination of tests.

	Evaluation Area	Examiner Title
☐	**Academic Achievement** These assessments measure reading, spelling, arithmetic, oral and written language skills, and/or general knowledge	______________
☐	**Health** Health information and testing is gathered to determine how your child's health affects school performance	______________
☐	**Intellectual Development** These assessments measure how well your child thinks, remembers, and solves problems.	______________
☐	**Language/Speech Communication Development** These assessments measure your child's ability to understand and use language and speak clearly and appropriately.	______________
☐	**Motor Development** These assessments measure how well your child coordinates body movements in small and large muscle activities. Perceptual skills may also be measured.	______________
☐	**Social/Emotional** These assessments indicate how your child feels about him/herself, gets along with others, takes care of personal needs at home, school and in the community.	______________
☐	**Adaptive/Behavior** These assessments indicate how your child takes care of personal needs at home, school and in the community.	______________

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☐	**Post-Secondary Transition** These assessments provide information related to transition training, education, employment, and where appropriate, independent living skills.	______________________
☐	**Other** ______________________________________	______________________
☐	**Alternative Means of Assessment** (Describe alternative methods of assessing the child, if applicable) ______________________________	______________________

Parents/Guardians have protections under state and federal procedural safeguard provisions. Please refer to the enclosed NOTICE OF PROCEDURAL SAFEGUARDS for an explanation of these rights. If you would like further information about your rights or the proposed action and/or referral please contact:

Print Name of District Contact	Position	Phone	E-mail Address
________________	________________	________________	________________

☐ I consent to the assessment. I understand that the results will be kept confidential and that I will be invited to attend the IEP team meeting to discuss the results. I also understand that no special education services will be provided to my child without my written consent.
☐ I do not consent to the proposed assessment described above.
☐ I would like the following assessment information to be considered by the IEP team ________________________________

Signature ______________________________________ Date ___/___/_____
☐ Parent ☐ Guardian ☐ Surrogate ☐ Adult Student

☐ If my child is or may become eligible for public benefits (Medi-Cal): I authorize the LEA/district to release student information for the limited purpose of billing Medi-Cal/Medicaid and to access Medi-Cal: health insurance benefits for applicable services.

Signature ______________________________________ Date ___/___/_____
☐ Parent ☐ Guardian ☐ Surrogate ☐ Adult Student

☐ Parent/Guardian/Student has received written notification of protections available to parents when LEA requests to access Medi-cal benefits

Address ________________________________ Phone number ________________

Comments ____

Date Received by District/LEA ____/____/______

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