

Student ID: [REDACTED]

WA SSID: [REDACTED]

Date of Birth: [REDACTED]

**Snohomish School District**

1601 Avenue D

Snohomish, WA 98290-1799

360-563-7308

**Notice of Meeting**

**PURPOSE:** This invitation requests your attendance at a meeting concerning the educational program/needs of your child. You have the opportunity to participate in any meeting regarding the identification, evaluation, educational placement, and the provision of a free appropriate public education for your child.

To: [REDACTED] Date Sent to Participants: 05/07/2019

This meeting has been scheduled for: Date 05/30/2019 Time 11:30 AM

Location Central Primary Center

If you have any questions or would like additional information or assistance to help you prepare for this Eligibility meeting, please contact Cheri Peach at 360-563-7321 e-mail [cheri.peach@sno.wednet.edu](mailto:cheri.peach@sno.wednet.edu).

This is to notify you that a/an Eligibility meeting has been scheduled for this student. Your participation and attendance at this meeting are very important. This Initial meeting must be scheduled at a mutually agreed upon time and place. The purpose of this meeting is to (check all that apply):

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Review Evaluation Reports | <input type="checkbox"/> Review Educational Progress |
| <input type="checkbox"/> Consider Transitional Services       | <input type="checkbox"/> Reevaluation Consideration  |
| <input checked="" type="checkbox"/> Eligibility Determination | <input type="checkbox"/> Other:                      |

The following are invited to attend and participate in the Initial meeting:

Parent  
 General Education Teacher  
 Special Education Teacher  
 Parent/Guardian  
 Other  
 District Representative  
 Other  
 Erin Matthews, MS, OTR/L , Occupational Therapist  
 Speech Language Pathologist

The parent/adult student or school may invite individuals who have knowledge or special expertise regarding the student, including related services personnel, to participate. The determination of the knowledge or special expertise shall be made by the person/party extending the invitation. You may also request, by contacting the individual named below, that a birth to three service coordinator be invited to participate in an initial IEP meeting if your child was previously served through an Individualized Family Service Plan (IFSP). If you, the parent or adult student, are bringing other individuals to the meeting, please let us know. This will ensure that the meeting space will accommodate all team members.

*Notice of Procedural Safeguards for Special Education Students and Their Families* has been provided to parents.

Student ID: [REDACTED]  
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Date of Birth: [REDACTED]

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360-563-7308

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**Contact Attempt Report**

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Notification Area: Eligibility  
Meeting Date: 05/30/2019  
Time: 11:30 AM  
Location: Central Primary Center

Method	Contact Date	Response Date	Response	Contact Name
Letter	05/07/2019	05/07/2019	Can Attend	[REDACTED]

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

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### Evaluation Summary

☒ Initial ☐ Reevaluation

Student Name: [REDACTED] Student ID No.: [REDACTED]

Birth Date: 05/30/2016 Grade: P2 Age: 3

School: SNOHOMISH CENTER

Evaluation Group Meeting Date: 05/30/2019 Next Three Year Reevaluation Due Date: 05/30/2022

Primary language of student: English Primary language at home: English

Parent(s) name(s): [REDACTED]

Parent interpreter needed? ☐ Yes ☒ No

Surrogate parent: ☒ No ☐ Yes If yes, name: \_\_\_\_\_

Evaluation Case Manager (Psychologist/SLP): Cheri Peach

Title: ECE TOSA

#### I. Review of Existing Data:

Date and reason for special education referral:

[REDACTED]

Description of specific strategies and interventions used to date and the effectiveness of each on student achievement and/or adjustment:

Academic or pre-academic record information:

#### II. Eligibility Decision:

Meets Eligibility Criteria: ☒ Yes ☐ No

Identified Disability Category:

[REDACTED]

The effects of the disability on the student's involvement and progress in the general curriculum; or for preschool children, in appropriate activities:

[REDACTED]

Student ID: [REDACTED]

WA SSID: [REDACTED]

Date of Birth: [REDACTED]

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## Evaluation Summary

Behavior Skills
1. <i>Behavior Skills</i>

**COMMUNICATION:**

[REDACTED]

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

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**Evaluation Summary**



Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

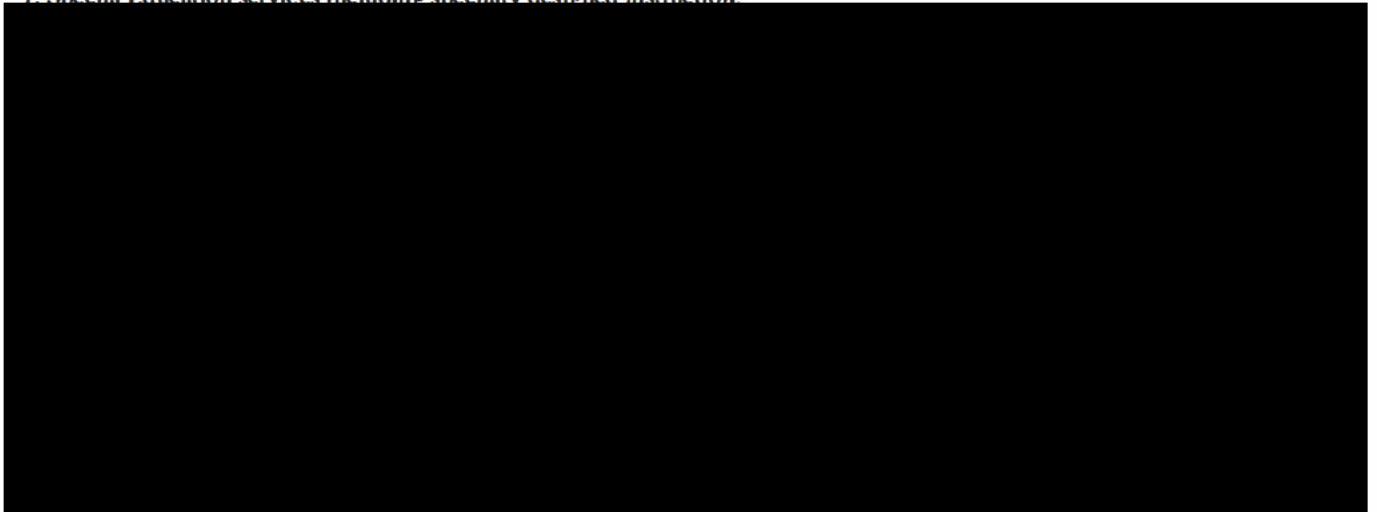
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### Evaluation Summary

#### **III. Recommendations to IEP (Individual Education Program) committee:**

##### **1. Special Education services including specially designed instruction:**



##### **2. Related services:**

##### **3. Supplementary Aids and Services:**

#### **IV. Assurances**

The District has conducted a full and individual evaluation of this student in all areas of suspected disability(ies) in accordance with the evaluation procedures contained in the Washington Administrative Code.

If eligible as specific learning disabled, a severe discrepancy was established between achievement and ability that is not correctable without special education and related services.

The findings of this evaluation are not primarily due to a lack of instruction in reading, math, or limited English proficiency.

##### **Consideration of Test Bias:**

This evaluation was administered with the understanding of test limitations which may result in bias because of cultural, economic, environmental or behavioral factors. However, such limitations have been considered and determined not to be a significant factor in current eligibility determination.

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**Evaluation Summary**

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Group Signatures (the date and signature of each professional member of the evaluation group below certifies that the evaluation report represents his/her conclusions. If the evaluation report does not reflect his/her conclusions, he/she must include a separate statement representing his/her conclusions.):

Evaluation Team Members, signatures and conclusions:

Dissenting  
Opinion  
|

Parent

Date

☐

General Education Teacher Not available for preschool aged students.

Date

☐

Special Education Teacher

Date

☐

Parent/Guardian

Date

☐

Other

Date

☐

District Representative

Date

☐

Other

Date

☐

Occupational Therapist Erin Matthews, MS, OTR/L

Date

☐

Speech Language Pathologist

Date

☐

Date

Date

Student ID: [REDACTED]  
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**Areas of Evaluation**

**Medical-Physical**

Examiner Name: Cheri Peach, ECE TOSA, 05/07/2019

Date: 09/18/2018

**Medical-Physical Findings:**

Health and Developmental History

[REDACTED]

Medical Diagnosis

[REDACTED]

Educational Implications

[REDACTED]



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**Areas of Evaluation**

**Student:**

**Vision and Hearing Screening:**

Hearing Test Date: 06/09/2016

Right Ear: Passed Left Ear: Passed

Vision Test Date: \_\_\_\_\_

Near

Far

Right Eye: \_\_\_\_\_ Right Eye: \_\_\_\_\_

Left Eye: \_\_\_\_\_ Left Eye: \_\_\_\_\_

**Cognitive**

Examiner Name: Cheri Peach, ECE TOSA, 05/07/2019

**Assessment Summary:**

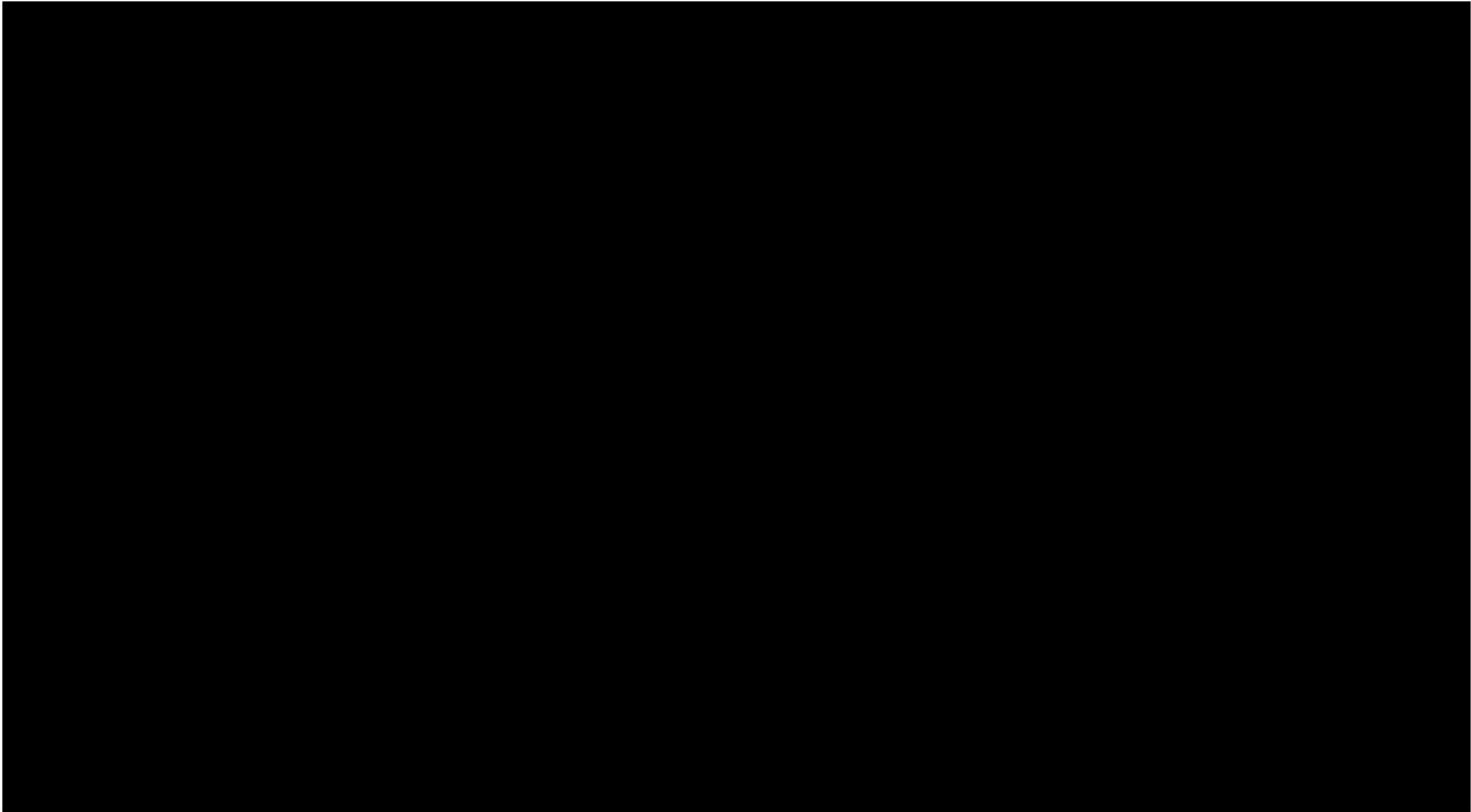
**Significant Findings:**

Student ID: [REDACTED]  
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**Areas of Evaluation**

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Student ID: [REDACTED]

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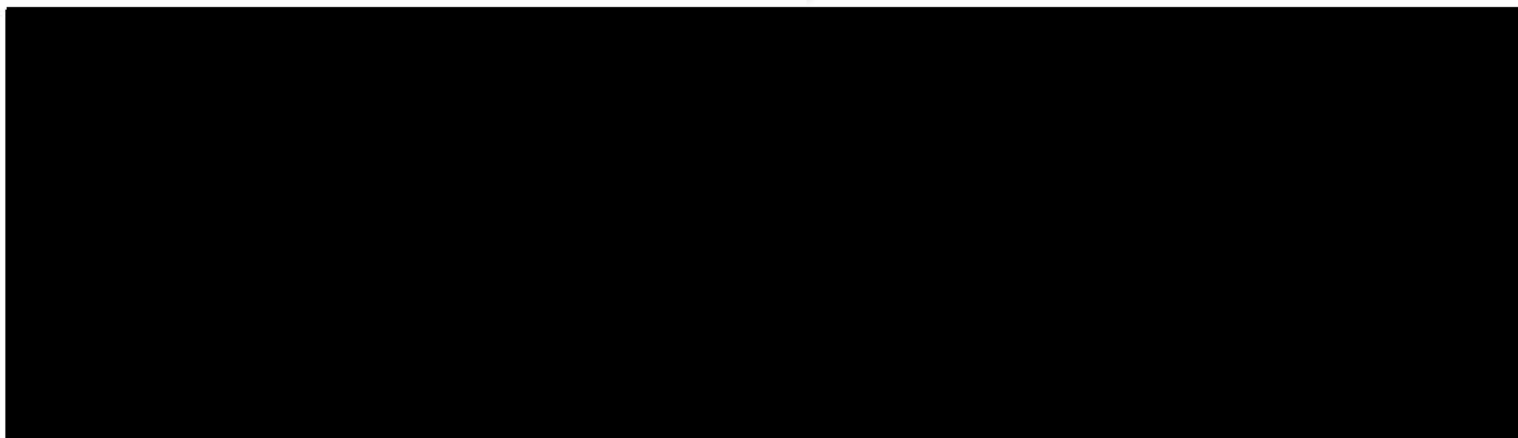
**Areas of Evaluation**

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Test Name :

Date(s) Given: 05/07/2019

Professional/Examiner: Cheri Peach

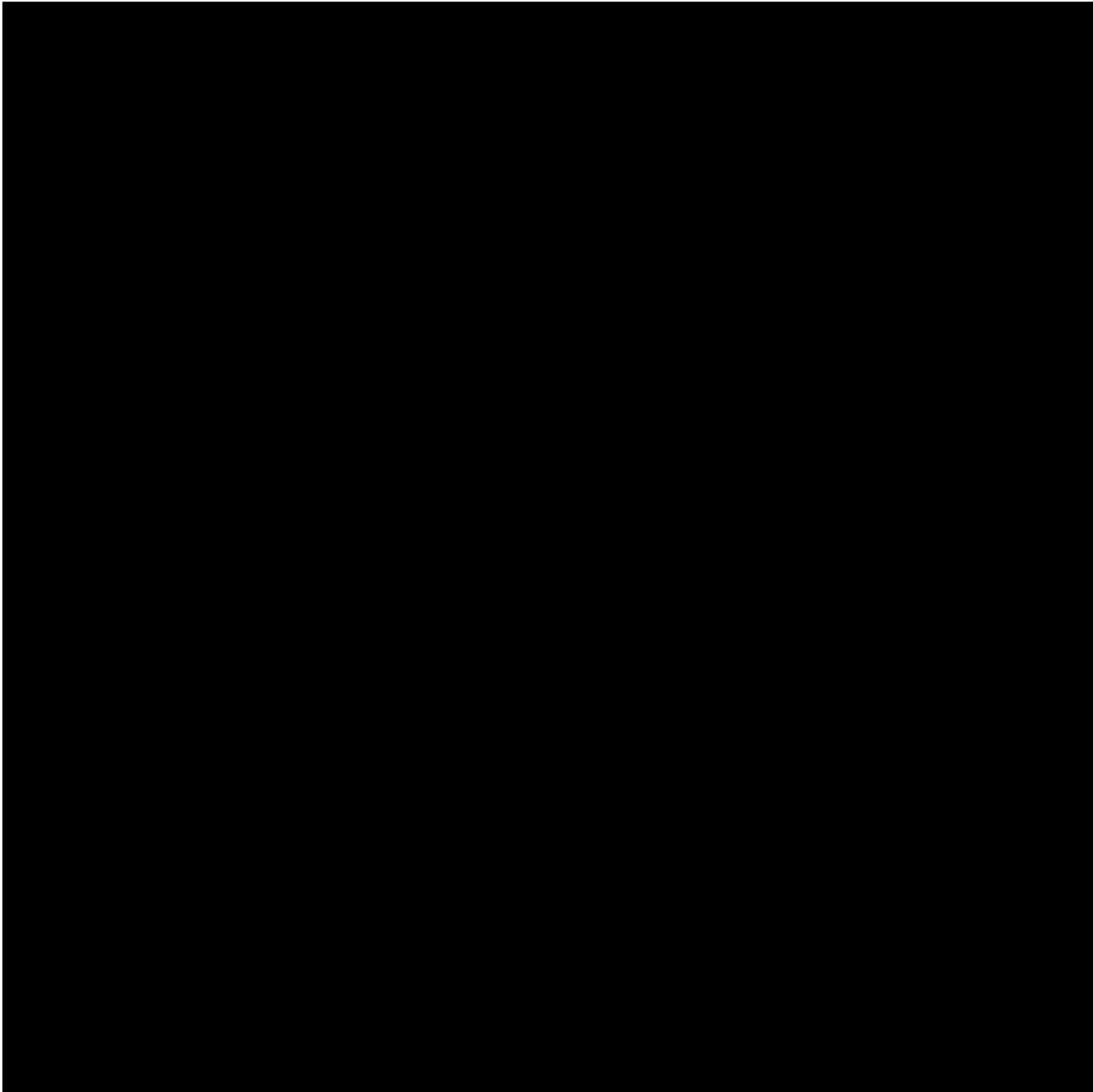


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**Areas of Evaluation**



Student ID: [REDACTED]  
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Date of Birth: [REDACTED]

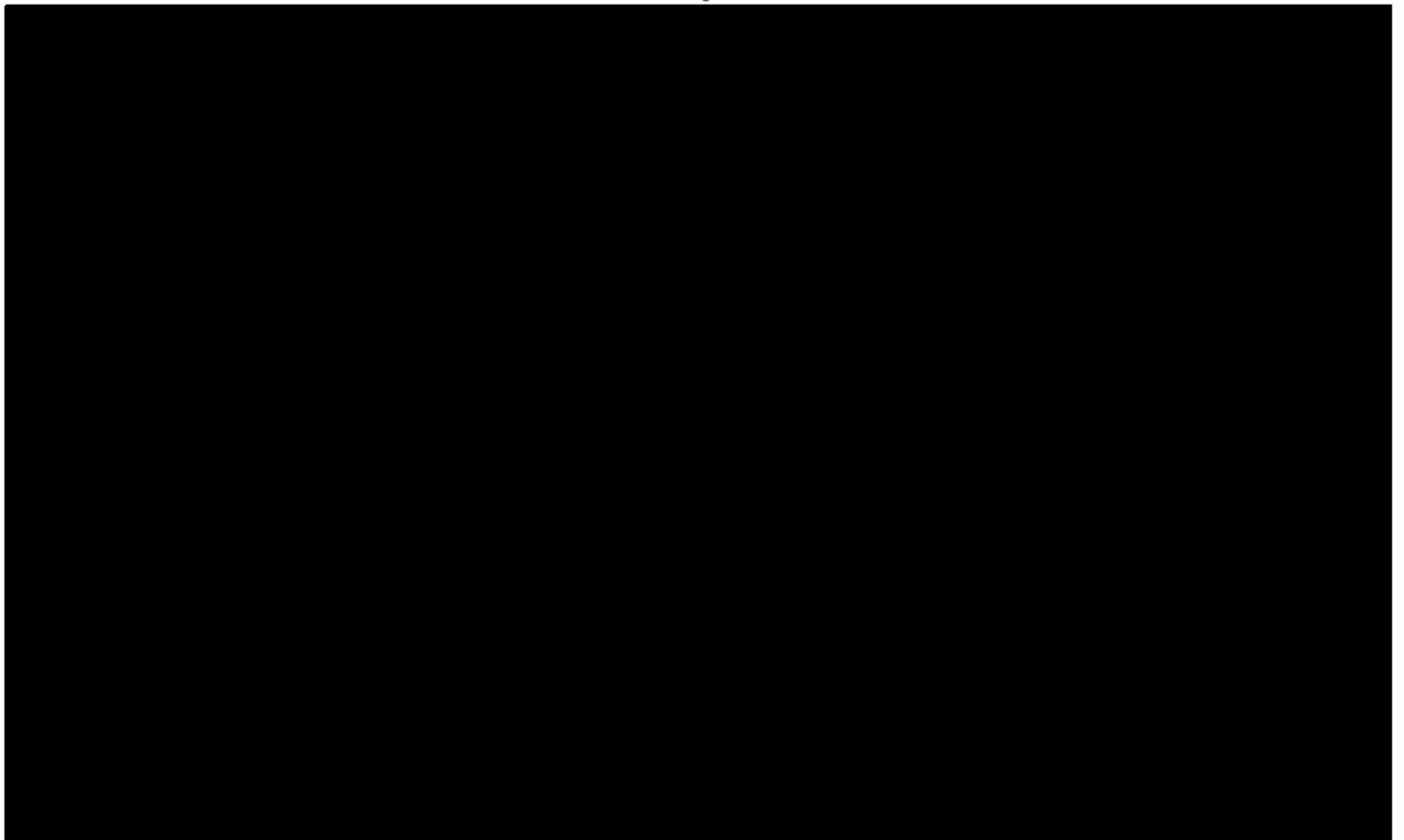
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**Areas of Evaluation**



**Adaptive**

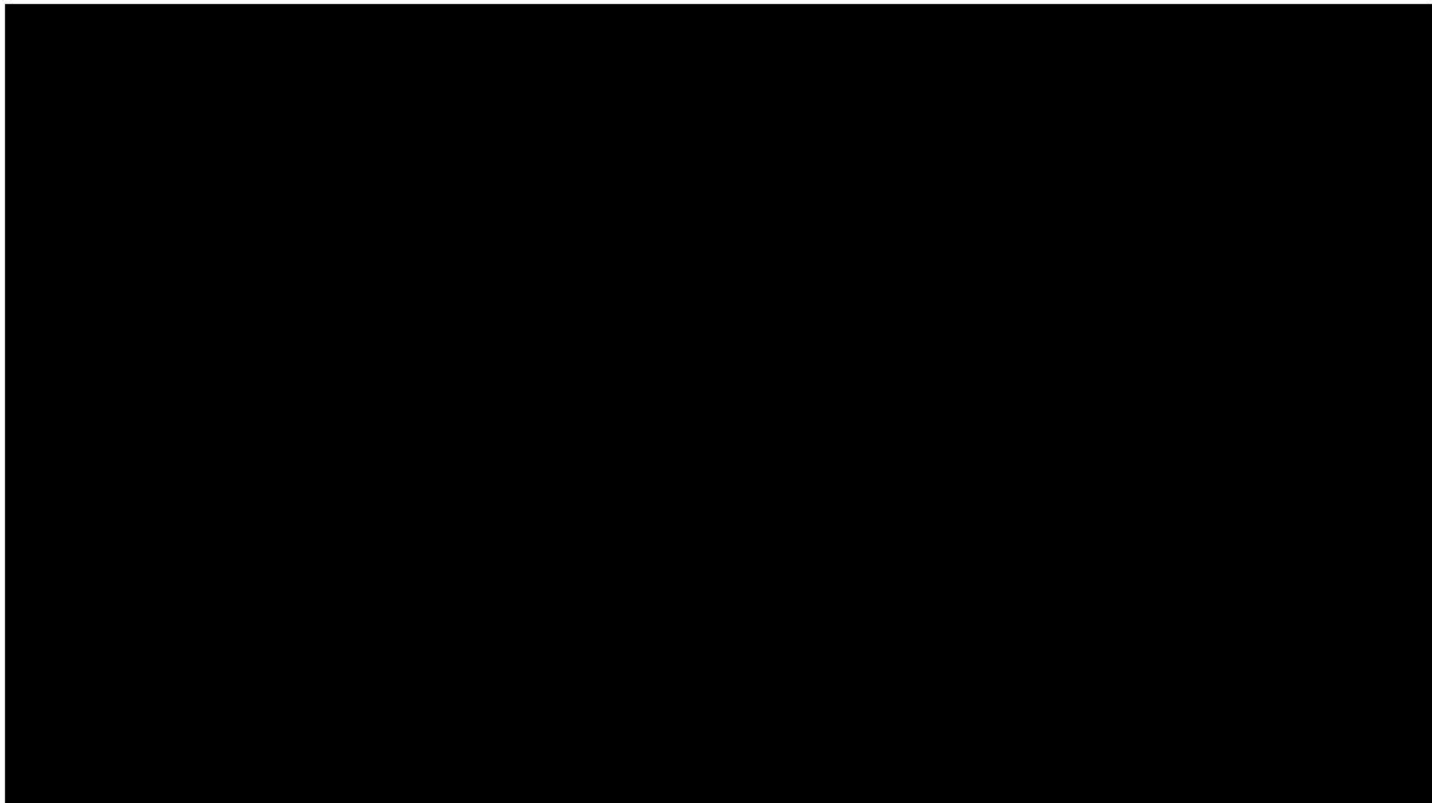


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**Areas of Evaluation**

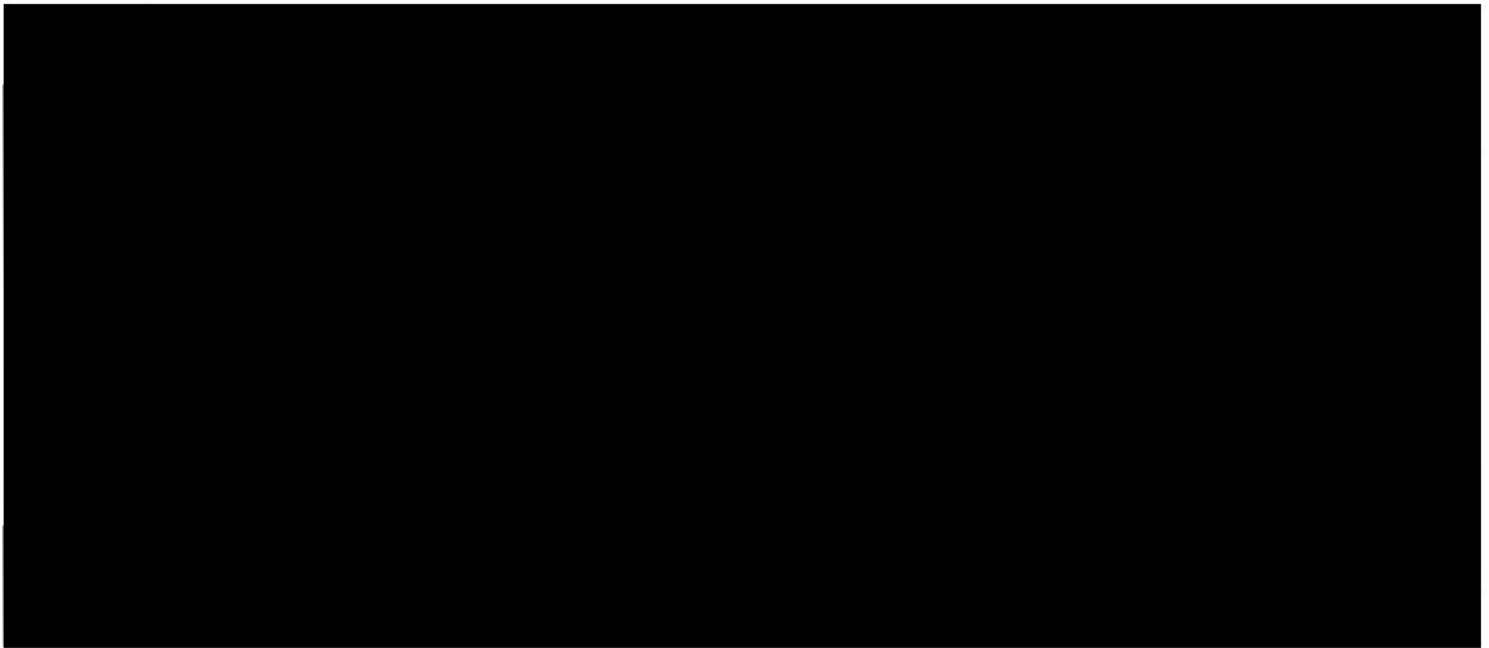


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**Areas of Evaluation**

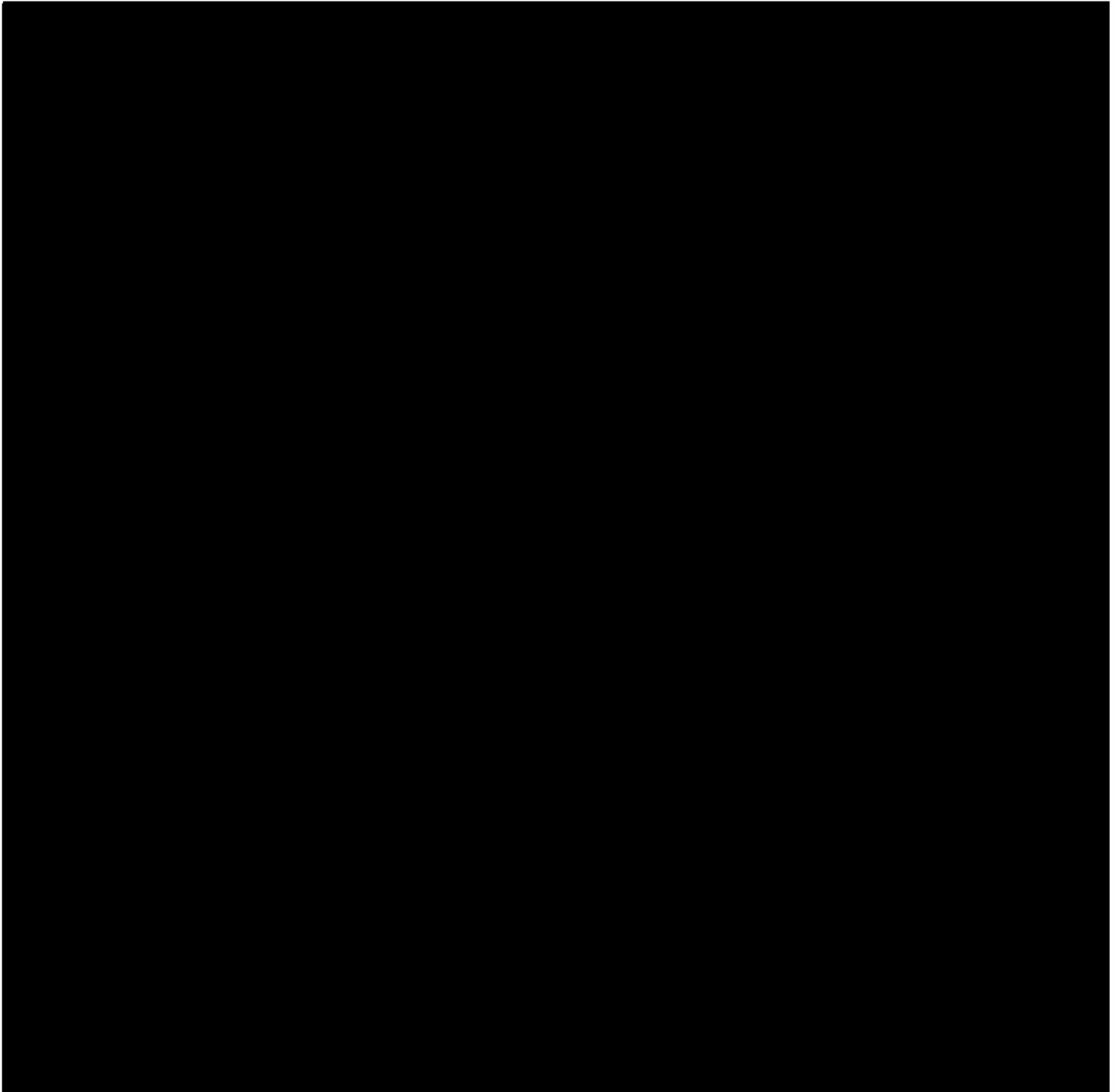


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**Areas of Evaluation**



**Fine Motor**

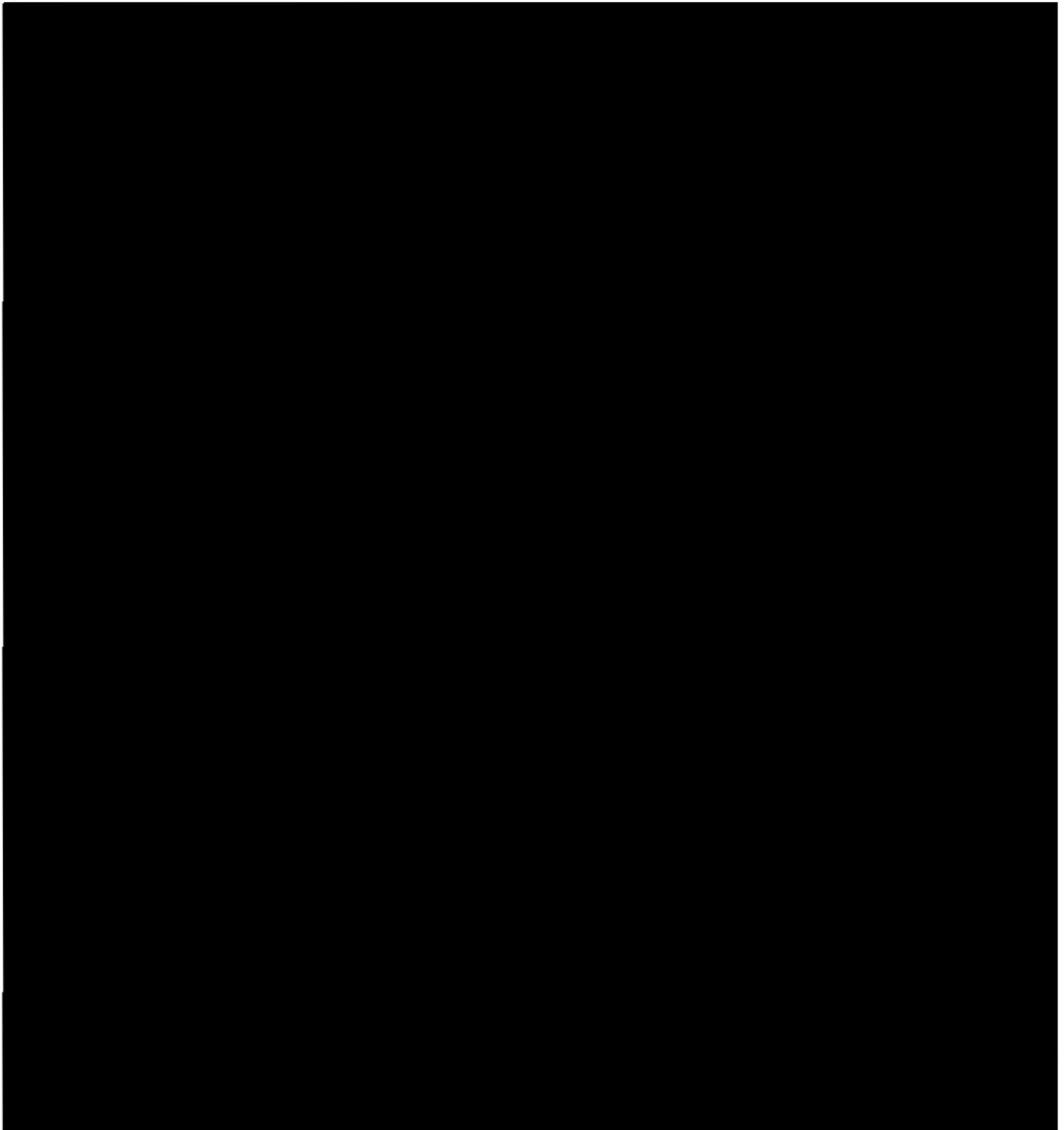


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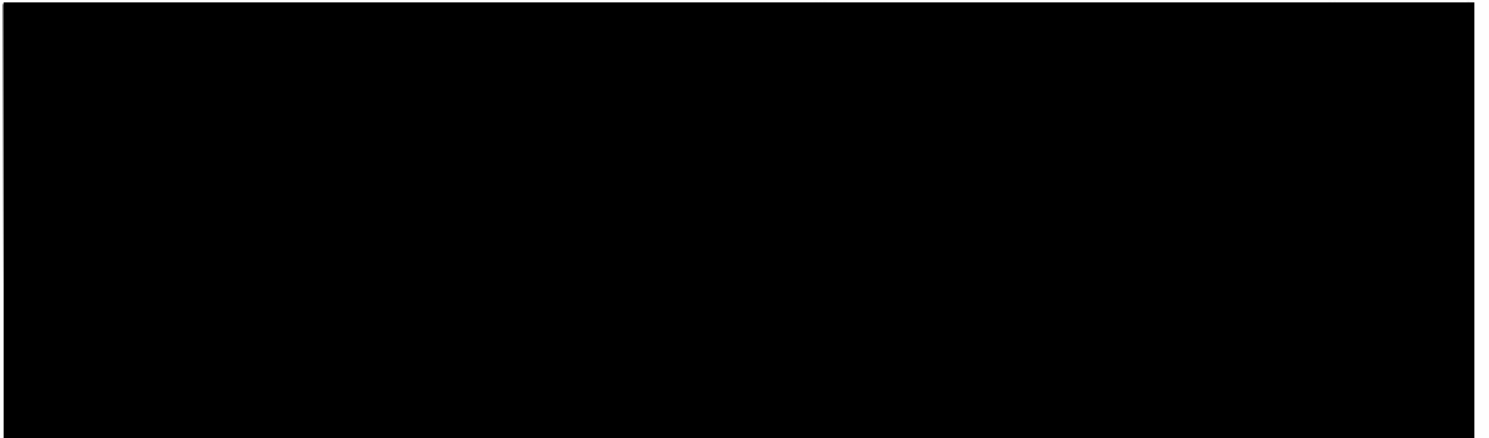
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**Areas of Evaluation**



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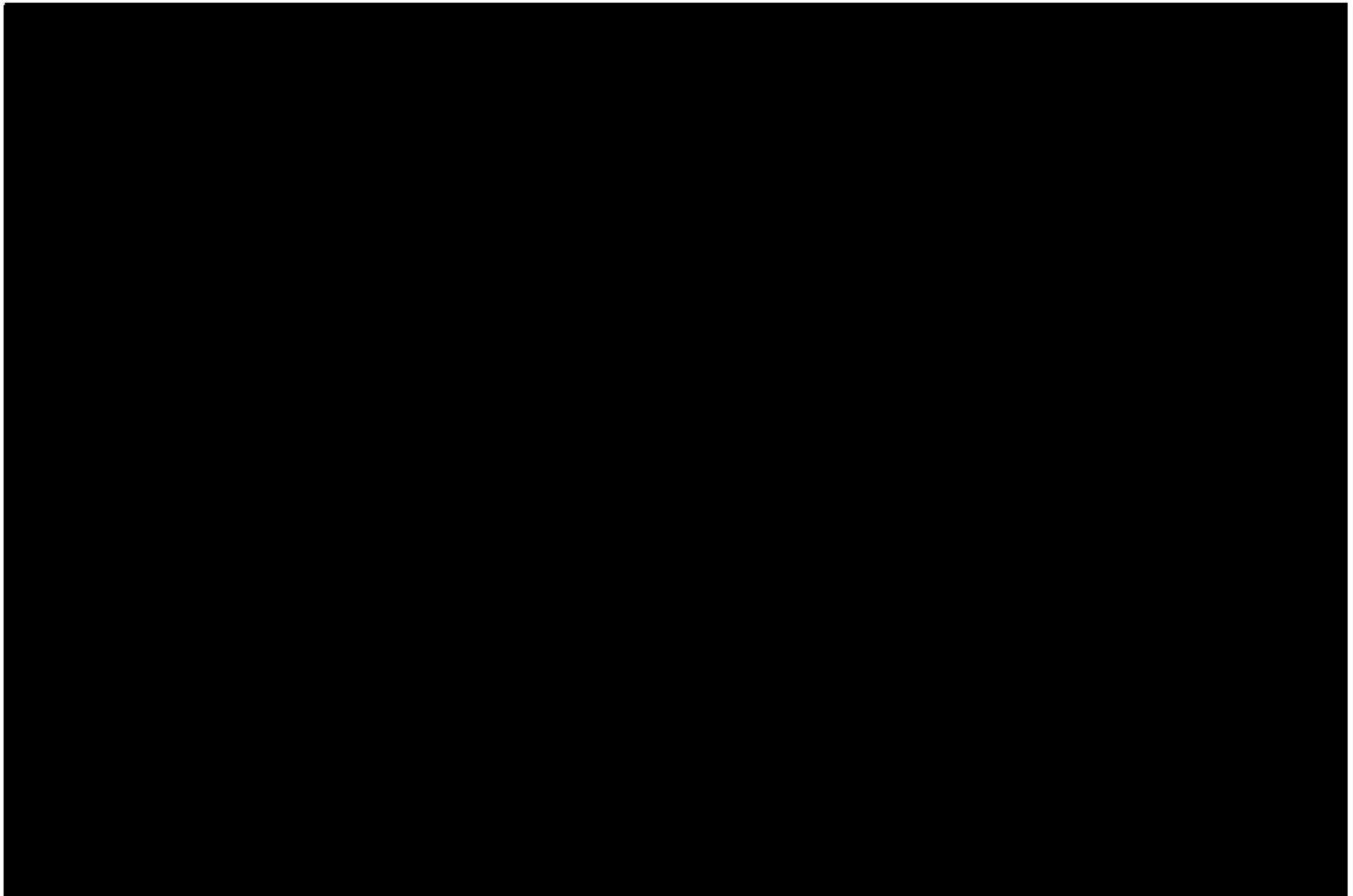


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**Areas of Evaluation**

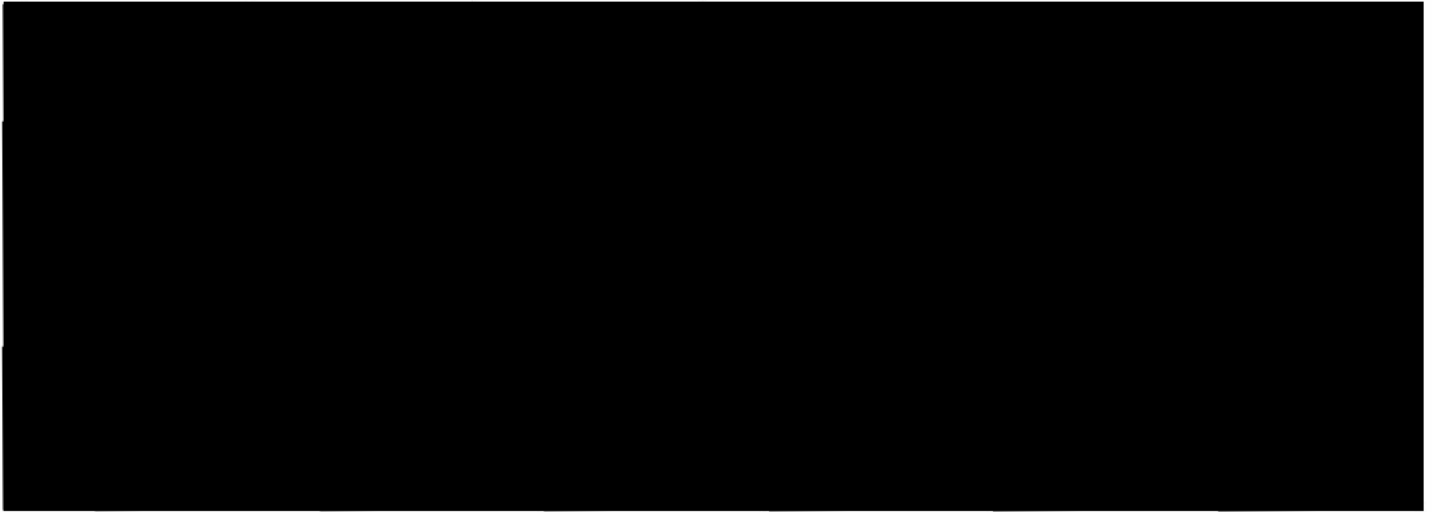


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**Areas of Evaluation**



Student ID: [REDACTED]  
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Date of Birth: [REDACTED]

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360-563-7308

**Prior Written Notice**

To: [REDACTED] Date: 05/21/2019  
Re: Student's Name: [REDACTED]

**PURPOSE:**As a parent/guardian of a special education child or child suspected of needing special education services, the school district is required to provide you with prior written notice whenever it proposes or refuses to initiate or change the identification, evaluation, educational placement, or provision of a free appropriate public education to your child. This notice should be given to you after a district makes a decision and before action is taken on the decision. The notice should be given to you in a reasonable amount of time before the district takes action.

The purpose of this prior written notice is to inform you that we are:

1. ☒ proposing ☐ refusing to 2. ☒ initiate ☐ change ☐ continue ☐ discontinue a/an  
(mark one of the above) (mark one of the above)

Mark all items below that apply:

3. ☐ Referral ☐ Initial Evaluation ☒ Eligibility Category  
☐ Educational Placement ☐ IEP ☐ Reevaluation  
☐ Disciplinary action that is a change of placement ☐ Other:

Description of the proposed or refused action:

[REDACTED]

The reason we are proposing or refusing to take action is:

[REDACTED]

Description of any other options considered and rejected:

[REDACTED]

The reasons we rejected those options were:

[REDACTED]

A description of each procedure, test, record, or report we used or plan to use as the basis for taking this action is as follows:

[REDACTED]

Any other factors that are relevant to the action:

[REDACTED]

The action will be initiated on: 05/30/2019

Your child has procedural protections under IDEA. These protections are explained in the *Notice of Procedural Safeguards for Special Education Students and Their Families*. If this prior written notice is given to you (1) as part of your child's initial referral for evaluation, (2) as part of a request for reevaluation or (3) notice to you regarding disciplinary action that constitutes a change of placement the procedural safeguards accompanies this notice. If a copy of the *Notice of Procedural Safeguards for Special Education Students and Their Families* is not enclosed and you would like a copy or you would like help in understanding the content, please contact:

Cheri Peach at 360-563-7321

*Notice of Procedural Safeguards for Special Education Students and Their Families* has been provided to parents.

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

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1601 Avenue D  
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**Notification for the Disclosure of Student Information to the Washington State Health Care Authority**

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Snohomish School District (the School District) currently provides necessary school-based health services to your child at no cost to you, the parent/guardian. The School District is participating in Washington State Health Care Authority (HCA) program through which Federal Medicaid funds are made available to school districts in the State to help cover the costs of providing necessary school-based health services to students. By participating in this program, the School District is allowed to seek Federal Medicaid funds to help cover the costs of the health services the School District provides to your child. In order to seek the Federal funds, the School District must disclose information from your child's education records to the HCA regarding the health services the School District provided to your child.

**NOTIFICATION OF PARENT/GUARDIAN RIGHTS AND PROTECTIONS**

To ensure that your child has access to a free appropriate public education, as required by Federal law, the School District must

- obtain your written consent prior to disclosing your child's health information to the HCA,
- may not require you to sign up for or enroll in any public benefits or insurance programs,
- may not require you to pay any out-of-pocket expenses such as a deductible or co-payment for the costs of the health services the School District provides to your child, and
- may not use your child's Medicaid or other public benefits if that use would
  - decrease available lifetime coverage or any other insured benefit,
  - result in you or your family paying for services that would otherwise be covered by Medicaid or other public insurance program and that are required for your child outside of the time that your child is in school,
  - increase your insurance premiums or lead to the discontinuation of any public benefits or insurance, or
  - risk the loss of your eligibility for home and community-based waivers, based on aggregate health-related costs.

*Giving your consent will cost you, the parent guardian, nothing*, but will allow the School District to seek Federal financial support needed to better provide services to students. Whether or not you give your consent or if you withdraw your consent, the School District will continue to provide services to your child at no cost to you, the parent/guardian.

If the district is requesting an updated consent from you, or has asked you to provide initial consent to verify Medicaid eligibility and seek reimbursement from Medicaid for necessary school based services, a consent form is attached to this notification.

Student ID: [REDACTED]

WA SSID: [REDACTED]

Date of Birth: [REDACTED]

**Snohomish School District**

1601 Avenue D

Snohomish, WA 98290-1799

360-563-7308

**Medicaid Consent**

Date: 05/30/2019

**PURPOSE:** This form asks for your consent to share the necessary information to verify Medicaid eligibility and bill for school-based Medicaid reimbursement with the Washington State Health Care Authority, Health and Recovery Services Administration. Billing HCA does not affect individual benefits under Medicaid or require a co-pay or deductible. If you have questions regarding this request, call the school district's Director of Special Education or designee for an explanation as to why the request is being made.

Student's Name: [REDACTED]

Student's SSID: [REDACTED]

Current School: SNOHOMISH CENTER

Date of Birth: [REDACTED]

State law requires the school district to submit claims for health-related services provided to special education students or students referred for special education. These services include physical therapy, occupational therapy, speech-language therapy, audiology, nursing, counseling, and psychological evaluation.

With your permission, Snohomish School District, will submit your student's name and birth date to the Washington State Health Care Authority (HCA) to verify Medicaid eligibility. Such a request will in no way negatively impact services included in your child's individualized education program (IEP).

With your permission, we will share necessary identifying information from your child's education record to access federal Medicaid reimbursement from the Washington State Health Care Authority (HCA). If any additional Medicaid reimbursement services are added to the IEP, the school district will request additional consent. If my child no longer is served by this school district, this consent does not transfer to a new district.

This authorization will begin on 05/30/2019.

By giving consent, you are acknowledging that (1) you have been fully informed of all information relevant to the activity for which consent is sought; (2) you understand that the granting of consent is voluntary on your part and may be revoked at any time; and (3) if you revoke consent, the revocation is not retroactive; which means that it does not negate any activity that has already taken place.

☒ I give my consent to verify Medicaid eligibility with HCA and to submit claims for allowable services.

☐ I do not give my consent to verify Medicaid eligibility with HCA and to submit claims for allowable services. I understand that my refusal does not affect my child's access to services under the Individualized Education Program.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date



Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

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1601 Avenue D  
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### Initial Individualized Education Program (IEP) Invitation

**PURPOSE:** This invitation requests your attendance at a meeting concerning the educational program/needs of your child. You have the opportunity to participate in any meeting regarding the identification, evaluation, educational placement, and the provision of a free appropriate public education for your child.

To: [REDACTED] Date Sent to Participants: 05/07/2019

This meeting has been scheduled for: Date 05/30/2019 Time 11:45 AM  
Location Central Primary Center

If you have any questions or would like additional information or assistance to help you prepare for this IEP meeting, please contact Brehanna Fraser-Bumatay at 360-563-4625 e-mail [brehanna.fraser-buma@sno.wednet.edu](mailto:brehanna.fraser-buma@sno.wednet.edu).

This is to notify you that a/an IEP meeting has been scheduled for this student. Your participation and attendance at this meeting are very important. This Initial meeting must be scheduled at a mutually agreed upon time and place. The purpose of this meeting is to (check all that apply):

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> Develop an Initial IEP | <input type="checkbox"/> Review Current IEP             |
| <input type="checkbox"/> Discuss Transition Services       | <input type="checkbox"/> Discuss Graduation             |
| <input type="checkbox"/> Discuss Annual Goal Progress      | <input type="checkbox"/> Review Instructional Needs     |
| <input type="checkbox"/> Consider Termination of Services  | <input checked="" type="checkbox"/> Determine Placement |
| <input type="checkbox"/> Develop ESY                       | <input type="checkbox"/> Discuss Attendance Issues      |
| <input type="checkbox"/> Manifestation Determination       | <input type="checkbox"/> Behavioral Intervention Plan   |
| <input type="checkbox"/> Other:                            |   |

The following are invited to attend and participate in the Initial meeting:

Parent  
Parent/Guardian  
Special Education Teacher  
Not available for preschool aged students. , General Education Teacher  
District Representative  
Other  
Occupational Therapist  
Speech Language Pathologist

The parent/adult student or school may invite individuals who have knowledge or special expertise regarding the student, including related services personnel, to participate. The determination of the knowledge or special expertise shall be made by the person/party extending the invitation. You may also request, by contacting the individual named below, that a birth to three service coordinator be invited to participate in an initial IEP meeting if your child was previously served through an Individualized Family Service Plan (IFSP). If you, the parent or adult student, are bringing other individuals to the meeting, please let us know. This will ensure that the meeting space will accommodate all team members.

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**Contact Attempt Report**

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Notification Area: Plan  
Meeting Date: 05/30/2019  
Time: 11:45 AM  
Location: Central Primary Center

Method	Contact Date	Response Date	Response	Contact Name
Letter	05/07/2019	05/07/2019	Can Attend	[REDACTED]

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

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**Individualized Education Program (IEP) Cover Page (Initial)**

Student's Name: [REDACTED]  
Grade: P4 Age\*: 3 Disability (if identified): [REDACTED]  
Parent/Guardian/Adult Student: [REDACTED] Primary language at home: English  
Parent interpreter needed? ☐ Yes ☐ No Surrogate parent: ☐ Yes ☒ No If yes, name: \_\_\_\_\_  
Home Address: [REDACTED]  
Phone # (H): [REDACTED] Phone # (W): [REDACTED]  
Attending School: SNOHOMISH CENTER Is this student's neighborhood school? ☐ Yes ☒ No

Most Recent Evaluation Date	<u>05/30/2019</u>	IEP Start Date	<u>09/11/2019</u>
Next re-evaluation must occur before	<u>05/30/2022</u>	Next IEP Start Date must occur on or before	<u>05/30/2020</u>
IEP Meeting Date	<u>05/30/2019</u>	Date parent notified of meeting	<u>05/07/2019</u>
Next IEP Meeting must occur before	<u>05/29/2020</u>	Date student notified of meeting (if transition will be discussed)	_____

Primary Staff Contact: Brehanna Fraser-Bumatay, Developmental Preschool Teacher  
Phone Number: 360-563-4625

Signatures are used to document participation in the meeting and do not constitute agreement or disagreement.

Excused	Title	Participant Name	Signature
<input type="checkbox"/>	Parent	_____	_____
<input type="checkbox"/>	Parent/Guardian	_____	_____
<input type="checkbox"/>	Special Education Teacher	_____	_____
<input type="checkbox"/>	General Education Teacher, Not available for preschool aged students	_____	_____
<input type="checkbox"/>	District Representative	_____	_____
<input type="checkbox"/>	Other	_____	_____
<input type="checkbox"/>	Occupational Therapist	_____	_____
<input type="checkbox"/>	Speech Language Pathologist	_____	_____
<input type="checkbox"/>		_____	_____
<input type="checkbox"/>		_____	_____

\* The student must be informed at least one year prior to turning 18 that the IDEA procedural safeguards (rights) transfer to him/her at age 18 and be provided with an explanation of those procedural safeguards.

Date informed: \_\_\_\_\_

Projected Graduation/Exit Date: \_\_\_\_\_

Student ID: [REDACTED]  
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**Individualized Education Program (IEP) Cover Page (Initial)**

Comments:

If the parent did not attend, what method was used to ensure their participation:

---

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

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### Team Considerations

Meeting Date: 05/30/2019

**PURPOSE:** During the IEP meeting the following factors must be considered by the IEP team. Best practice suggests that the IEP team document that the factors were considered and any decision made relative to each. The factors are addressed in other sections of the IEP if not documented on this page. (for example: see Present Levels of Academic and Functional Performance)

- ☒ The strengths of the student and the concerns of the parents for enhancing the education of their child.  
[REDACTED]  
[REDACTED]
- ☒ The results of the student's performance on any general state or district-wide assessments.  
[REDACTED]
- ☒ The communication needs of the student. In the case of a student who is deaf or hard of hearing, consider the student's language and communication needs, opportunities for direct communications with peers and professional personnel in the student's language and communication mode, academic level, and full range of needs, including opportunities for direct instruction in the student's language and communication mode.  
[REDACTED]
- ☒ The student's assistive technology devices and services needs.  
[REDACTED]
- ☒ In the case of a student whose behavior impedes his or her learning or that of others, consider, when appropriate, strategies, including positive behavioral interventions, strategies, and supports to address that behavior.  
[REDACTED]
- ☒ In the case of a student with limited English proficiency, consider the language needs of the child as such needs relate to the child's IEP.  
[REDACTED]
- ☒ In the case of a student who is blind or has a visual impairment, provide for instruction in Braille and the use of Braille unless the IEP team determines, after an evaluation of the student's reading and writing skills, needs, and appropriate reading and writing media (including an evaluation of the student's future needs for instruction in Braille or the use of Braille), that instruction in Braille or the use of Braille is not appropriate for the student.  
[REDACTED]

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

Snohomish School District  
1601 Avenue D  
Snohomish, WA 98290-1799  
360-563-7308

### Present Levels of Educational Performance and Measurable Annual Goals

Meeting Date: 05/30/2019

**PURPOSE:** The Present Level of Educational Performance describes the effects of the student's disability upon the student's involvement and progress in the general curriculum and area(s) of need. This includes the student's performance in academic achievement (reading, math, communications, etc.) and functional performance (behavior, social skills, daily life activities, mobility, extra-curricular activities, etc.) in objective terms. Test scores, if appropriate, should be self-explanatory or an explanation should be included. For preschool students this section should include how the student's disability affects the student's participation in appropriate activities. **There should be a direct relationship between the present level of educational performance and the other components of the IEP.**

#### General Education Teacher Report

[REDACTED]

#### >> Adverse Impact Summary

[REDACTED]

[REDACTED]

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

Snohomish School District  
1601 Avenue D  
Snohomish, WA 98290-1799  
360-563-7308

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**Present Levels of Educational Performance and Measurable Annual Goals**

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Meeting Date: 05/30/2019

[REDACTED]

[REDACTED]

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

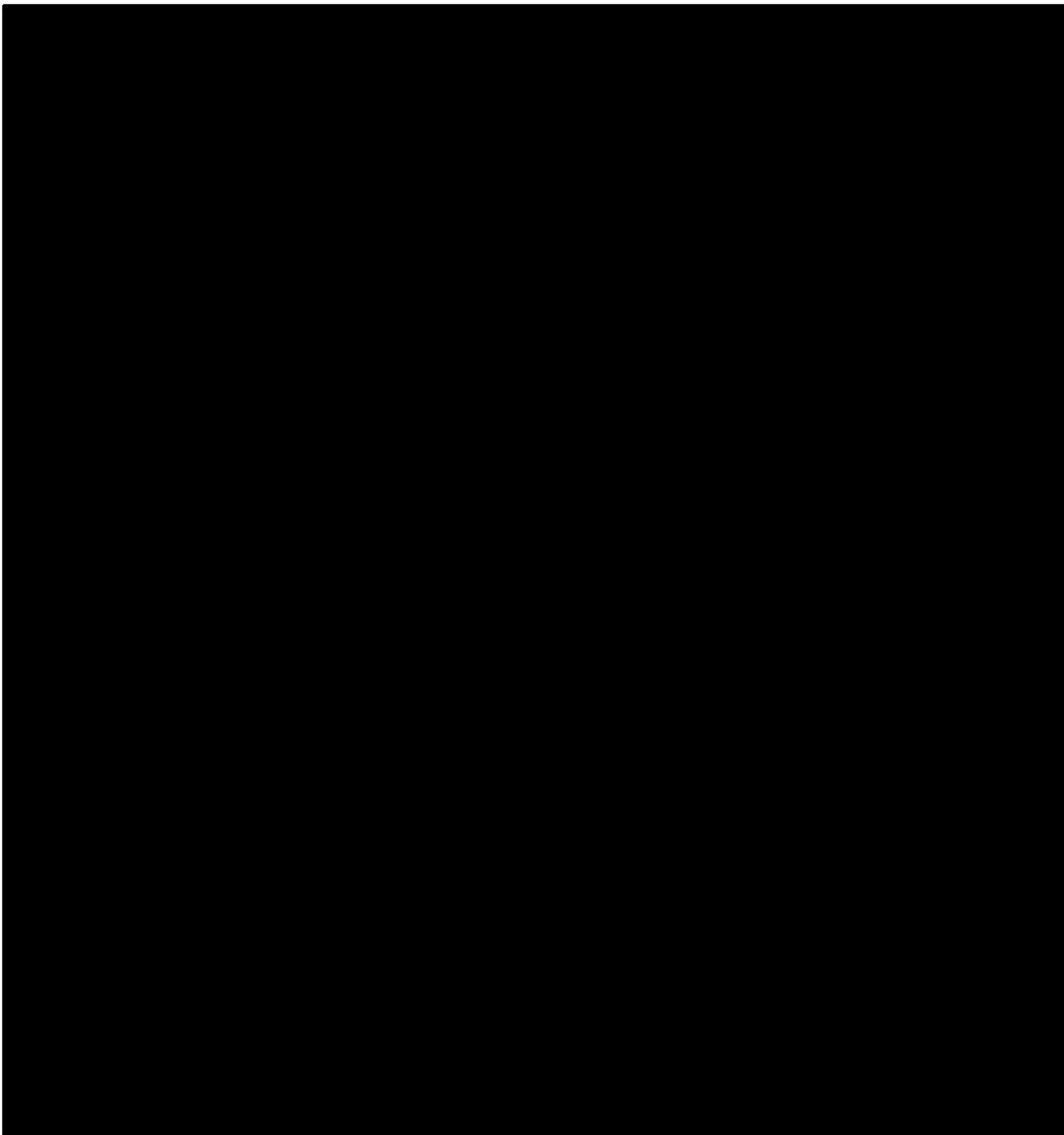
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1601 Avenue D  
Snohomish, WA 98290-1799  
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**Present Levels of Educational Performance and Measurable Annual Goals**

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Meeting Date: 05/30/2019



Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

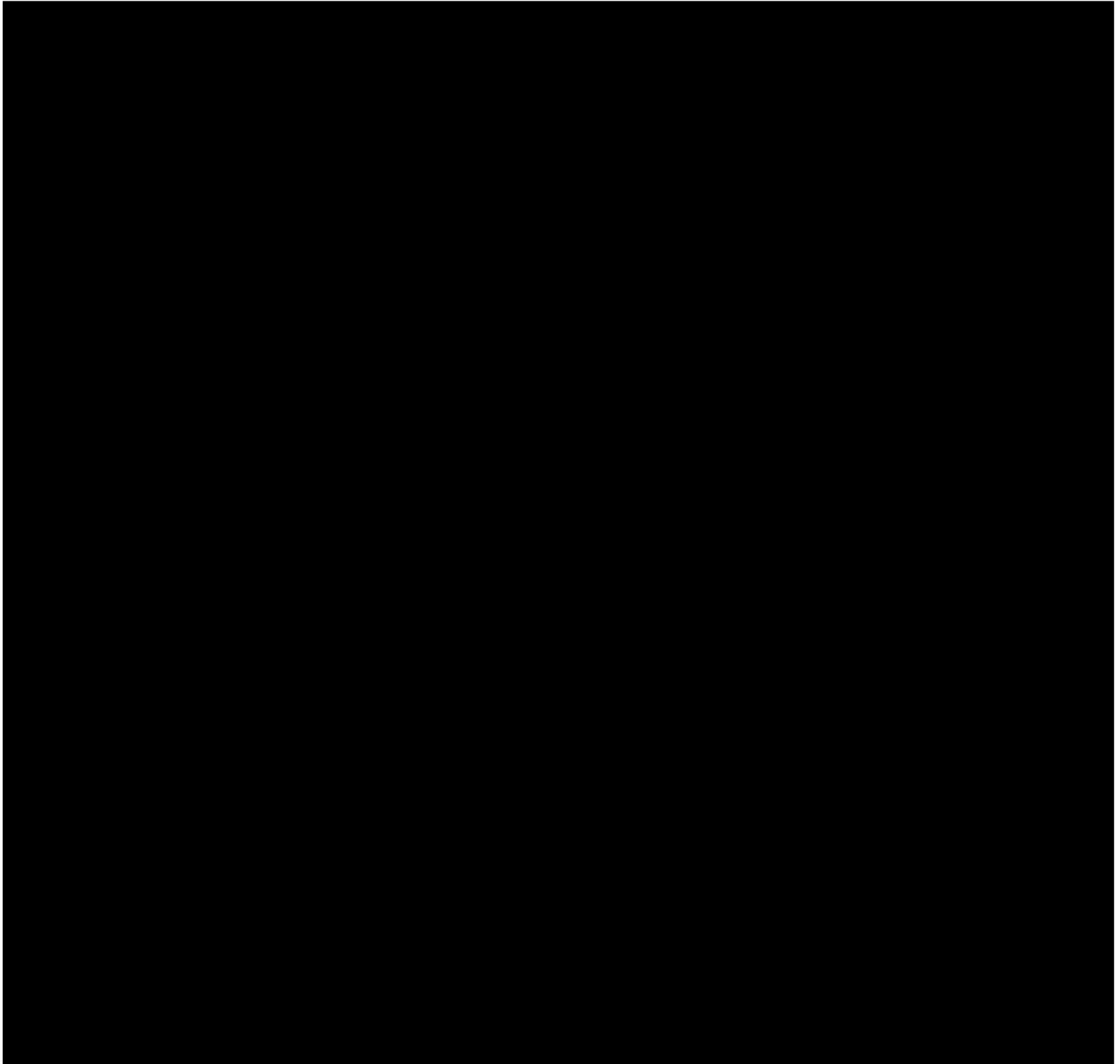
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1601 Avenue D  
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**Present Levels of Educational Performance and Measurable Annual Goals**

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Meeting Date: 05/30/2019





Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

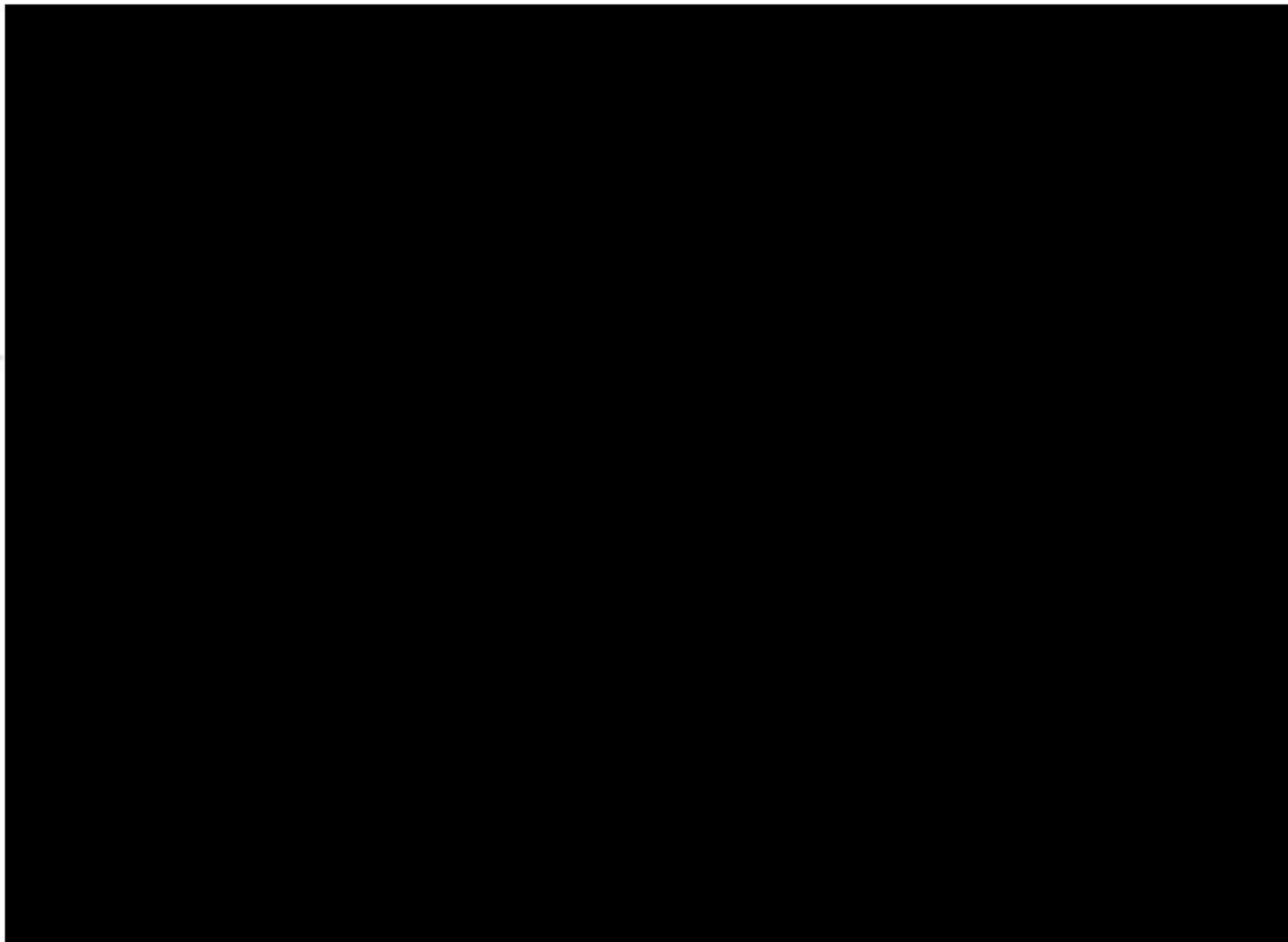
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1601 Avenue D  
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360-563-7308

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**Present Levels of Educational Performance and Measurable Annual Goals**

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Meeting Date: 05/30/2019



Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

Snohomish School District  
1601 Avenue D  
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360-563-7308

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**Program Accommodations/ Modifications and Support for School Personnel**

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Meeting Date: 05/30/2019

**PURPOSE:** The purpose of this page is to document the modifications and/or accommodations that the student requires, based on the student's assessed needs, in order to advance appropriately toward attaining the identified annual goals, to be involved and make progress in the general education curriculum, and to be educated with non-disabled peers to the maximum extent appropriate. Accommodations may be in, but not limited to, the areas of presentation, timing/scheduling, setting, aids, and format. The impact of any modifications listed should be discussed. This includes the earning of credits for graduation.

This student will be provided access to the general education, special education, other school services and activities including non-academic activities and extracurricular activities, and education related settings:

- ☒ with no accommodations/modifications  
☐ with the following accommodations/modifications

Modifications/Accommodations not necessary.

**Supports for School Personnel** (training, professional development, etc):

Supports for school personnel not necessary.

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

Snohomish School District  
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Snohomish, WA 98290-1799  
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State or Districtwide Assessments of Student Achievement

Meeting Date: 05/30/2019

**PURPOSE:**The IEP team makes the determination of what type of state and district wide assessments (regular or alternative) the student will take and what individual accommodations are necessary. Accommodations provided on state and districtwide assessments should be those that are provided as part of the regular instructional program.

Assessment	Accommodations		If YES, List Accommodation(s) by Assessment
	Yes	No	
Current Grade Tests			
Next Grade Tests			

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

**Snohomish School District**  
1601 Avenue D  
Snohomish, WA 98290-1799  
360-563-7308

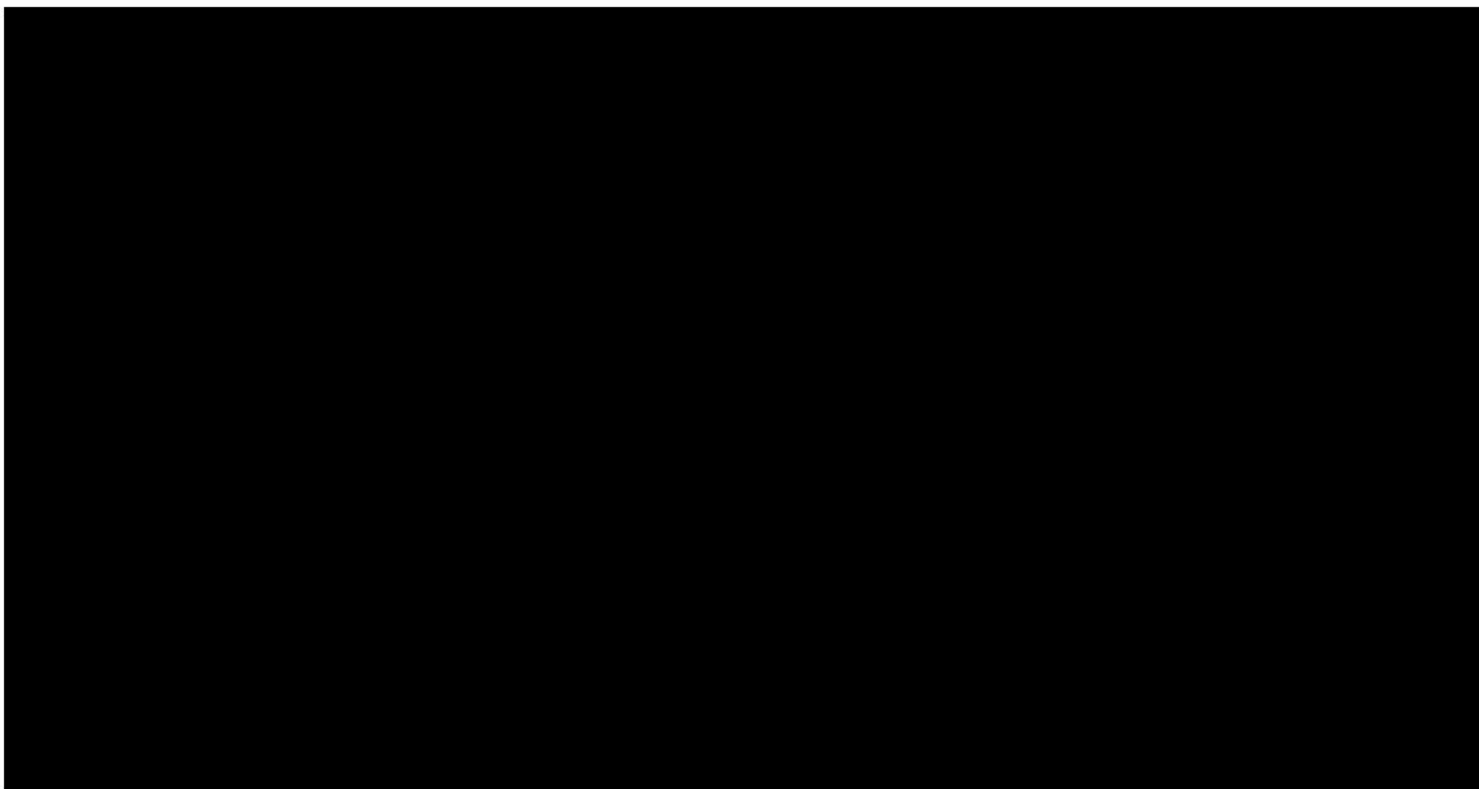
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**Special Education and Related Services**

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Meeting Date: 05/30/2019

**PURPOSE:** The information on this page is a summary of the student's program/services, including when services will begin, where they will be provided, who will be responsible for providing them, and when they will end.



Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

Snohomish School District  
1601 Avenue D  
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360-563-7308

### Special Education and Related Services

**PURPOSE:** The purpose of this page is to document the extent to which the student will be involved and progress in the general curriculum, participate in extracurricular and nonacademic activities and be educated and participate with other special education students and non-disabled students. Other education-related factors that may impact the student should also be considered.

#### Least Restrictive Environment (LRE):

When discussing least restrictive environment and placement options, the following must be considered:

- To the maximum extent appropriate, the student is educated with children without disabilities.
- The placement should provide a reasonably high probability of assisting the student in attaining the annual goals.
- Special classes, separate schooling, or other removal of the student from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.
- The student's placement should be as close as possible to the child's home and unless the IEP of the student with a disability requires some other arrangement, the student is educated in the school that he or she would attend if he or she did not have a disability.
- In selecting the LRE, consideration is given to any potential harmful effect on the student or on the quality of services that he/she needs.
- The student with a disability is not removed from education in age-appropriate regular classrooms solely because of needed modifications in the general curriculum.

An explanation of the extent, if any, to which the student will not participate with nondisabled students in the general education classroom, and in nonacademic and extracurricular activities:

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

Snohomish School District  
1601 Avenue D  
Snohomish, WA 98290-1799  
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**Special Education and Related Services**

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[REDACTED]

**Parent Notification Procedures:**

The district has a procedure for notifying parents regarding the use of restraint or isolation. A copy of the district's procedure is attached to this IEP.

**Other Considerations:**

Extended School Year: ☐ Yes ☒ No      If Yes, must complete ESY form.  
Emergency Response Protocol: ☐ Yes ☒ No

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

Snohomish School District  
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360-563-7308

### Written Parental Consent for Initial Special Education Services

#### REQUIRED FOR INITIAL PLACEMENT ONLY: WRITTEN PARENTAL PERMISSION

*My rights and those of my child regarding procedural safeguards have been fully explained. I understand that my child requires special education and before initial placement to receive special education and related services may occur, I must give consent for services. I understand when I give consent, it is voluntary, and that while it can be revoked, revocation is not retroactive. This means that the revocation does not undo services that occurred after my consent was given and before my consent was revoked. If I refuse consent, I understand that the district may not request mediation to obtain my consent or ask for a due process hearing to override my consent. If I do not give consent for initial services, the district may not provide services until I provide written consent.*

*The district may not ask an Administrative Law Judge to override your denial of consent for the initial placement of special education and related services. However, if you do not provide consent for initial placement of special education and related services, the district will not be considered to be in violation of the requirement to make a free, appropriate, public education (FAPE) available to your child.*

#### Parent Response for initial Provision of Special Education Services

- ☒ I give consent for my child to receive initial special education services  
☐ I do not give consent for my child to receive initial special education services

Reason for not giving consent: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

Snohomish School District  
1601 Avenue D  
Snohomish, WA 98290-1799  
360-563-7308

### Prior Written Notice

To: [REDACTED] Date: 05/30/2019  
Re: Student's Name: [REDACTED]

**PURPOSE:** As a parent/guardian of a special education child or child suspected of needing special education services, the school district is required to provide you with prior written notice whenever it proposes or refuses to initiate or change the identification, evaluation, educational placement, or provision of a free appropriate public education to your child. This notice should be given to you after a district makes a decision and before action is taken on the decision. The notice should be given to you in a reasonable amount of time before the district takes action.

The purpose of this prior written notice is to inform you that we are:

1. ☒ proposing ☐ refusing to 2. ☒ initiate ☐ change ☐ continue ☐ discontinue a/an  
(mark one of the above) (mark one of the above)

Mark all items below that apply:

3. ☐ Referral ☐ Initial Evaluation ☐ Eligibility Category  
☒ Educational Placement ☒ IEP ☐ Reevaluation  
☐ Disciplinary action that is a change of placement ☐ 504 Plan ☐ Other:

Description of the proposed or refused action:

[REDACTED]

The reason we are proposing or refusing to take action is:

[REDACTED]

Description of any other options considered and rejected:

[REDACTED]

The reasons we rejected those options were:

[REDACTED]

A description of each procedure, test, record, or report we used or plan to use as the basis for taking this action is as follows:

[REDACTED]

Any other factors that are relevant to the action:

[REDACTED]

The action will be initiated on: 09/11/2019



Student ID: [REDACTED]

WA SSID: [REDACTED]

Date of Birth: [REDACTED]

**Snohomish School District**

1601 Avenue D

Snohomish, WA 98290-1799

360-563-7308

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**Prior Written Notice**

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Your child has procedural protections under IDEA. These protections are explained in the *Notice of Procedural Safeguards for Special Education Students and Their Families*. If this prior written notice is given to you (1) as part of your child's initial referral for evaluation, (2) as part of a request for reevaluation or (3) notice to you regarding disciplinary action that constitutes a change of placement the procedural safeguards accompanies this notice. If a copy of the *Notice of Procedural Safeguards for Special Education Students and Their Families* is not enclosed and you would like a copy or you would like help in understanding the content, please contact:

Brehanna Fraser-Bumatay

at

360-563-4625

The district has a policy for notifying parents regarding the use of restraint or isolation. A copy of this policy is attached to this IEP.

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

**Snohomish School District**  
1601 Avenue D  
Snohomish, WA 98290-1799  
360-563-7308

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**Notification for the Disclosure of Student Information to the Washington State Health Care Authority**

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Snohomish School District (the School District) currently provides necessary school-based health services to your child at no cost to you, the parent/guardian. The School District is participating in Washington State Health Care Authority (HCA) program through which Federal Medicaid funds are made available to school districts in the State to help cover the costs of providing necessary school-based health services to students. By participating in this program, the School District is allowed to seek Federal Medicaid funds to help cover the costs of the health services the School District provides to your child. In order to seek the Federal funds, the School District must disclose information from your child's education records to the HCA regarding the health services the School District provided to your child.

**NOTIFICATION OF PARENT/GUARDIAN RIGHTS AND PROTECTIONS**

To ensure that your child has access to a free appropriate public education, as required by Federal law, the School District must

- obtain your written consent prior to disclosing your child's health information to the HCA,
- may not require you to sign up for or enroll in any public benefits or insurance programs,
- may not require you to pay any out-of-pocket expenses such as a deductible or co-payment for the costs of the health services the School District provides to your child, and
- may not use your child's Medicaid or other public benefits if that use would
  - decrease available lifetime coverage or any other insured benefit,
  - result in you or your family paying for services that would otherwise be covered by Medicaid or other public insurance program and that are required for your child outside of the time that your child is in school,
  - increase your insurance premiums or lead to the discontinuation of any public benefits or insurance, or
  - risk the loss of your eligibility for home and community-based waivers, based on aggregate health-related costs.

*Giving your consent will cost you, the parent guardian, nothing*, but will allow the School District to seek Federal financial support needed to better provide services to students. Whether or not you give your consent or if you withdraw your consent, the School District will continue to provide services to your child at no cost to you, the parent/guardian.

If the district is requesting an updated consent from you, or has asked you to provide initial consent to verify Medicaid eligibility and seek reimbursement from Medicaid for necessary school based services, a consent form is attached to this notification.

Student ID: [REDACTED]  
WA SSID: [REDACTED]  
Date of Birth: [REDACTED]

**Snohomish School District**  
1601 Avenue D  
Snohomish, WA 98290-1799  
360-563-7308

### Medicaid Consent

Date: 05/30/2019

**PURPOSE:** This form asks for your consent to share the necessary information to verify Medicaid eligibility and bill for school-based Medicaid reimbursement with the Washington State Health Care Authority, Health and Recovery Services Administration. Billing HCA does not affect individual benefits under Medicaid or require a co-pay or deductible. If you have questions regarding this request, call the school district's Director of Special Education or designee for an explanation as to why the request is being made.

Student's Name: [REDACTED]

Student's SSID: [REDACTED]

Current School: SNOHOMISH CENTER

Date of Birth: [REDACTED]

State law requires the school district to submit claims for health-related services provided to special education students or students referred for special education. These services include physical therapy, occupational therapy, speech-language therapy, audiology, nursing, counseling, and psychological evaluation.

With your permission, Snohomish School District, will submit your student's name and birth date to the Washington State Health Care Authority (HCA) to verify Medicaid eligibility. Such a request will in no way negatively impact services included in your child's individualized education program (IEP).

With your permission, we will share necessary identifying information from your child's education record to access federal Medicaid reimbursement from the Washington State Health Care Authority (HCA). If any additional Medicaid reimbursement services are added to the IEP, the school district will request additional consent. If my child no longer is served by this school district, this consent does not transfer to a new district.

This authorization will begin on 05/30/2019.

By giving consent, you are acknowledging that (1) you have been fully informed of all information relevant to the activity for which consent is sought; (2) you understand that the granting of consent is voluntary on your part and may be revoked at any time; and (3) if you revoke consent, the revocation is not retroactive; which means that it does not negate any activity that has already taken place.

☒ I give my consent to verify Medicaid eligibility with HCA and to submit claims for allowable services.

☐ I do not give my consent to verify Medicaid eligibility with HCA and to submit claims for allowable services. I understand that my refusal does not affect my child's access to services under the Individualized Education Program.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date