

Student Name: _____ Report Date: _____
 Birth Date: _____ Grade: _____ School Building: _____
 School District: _____ Parent/Guardian: _____

PURPOSE

This form will be used by the Evaluation Team to recommend: (Choose one)

- Initial eligibility** for special education.
 (Behind this page attach a copy of all referenced documents and a copy of the Consent for Initial Evaluation)
- Redetermination of eligibility** for special education.
 (Behind this page attach a copy of all referenced documents and the REED)

EVALUATION SUMMARY
Include enough detail to determine a starting point for instruction

Area of Evaluation	Data Source	Performance Level	Name/Date of Attached Report/Document
• Ability Level			
• Achievement Level			
• Adaptive Behavior			
• Educational Performance			
• Information from Parents			

DIAGNOSTIC ASSURANCE AND DOCUMENTATION

The Evaluation Team must consider the following assurance statements before making a recommendation regarding this student’s eligibility:

- This student manifests impairment during the developmental period with all of the following behavioral characteristics:
 - Developmental rate at or below approximately two standard deviations below the mean as determined through intellectual assessment Yes No
 - Scores approximately within the lowest six percentiles on a standardized test in reading and arithmetic (If age and developmentally appropriate for formal or standardized achievement tests) Yes No
 - A lack of development primarily in cognitive domain Yes No
 - Impairment of adaptive behavior Yes No
 - Adverse educational performance Yes No
- The student needs special education or related services or both Yes No

EXCLUSIONARY CONSIDERATIONS

- Was the determinant factor for eligibility a result of:
 - Lack of instruction in reading and math? Yes No
 - Limited English proficiency? Yes No

ELIGIBILITY RECOMMENDATION

The Evaluation Team 1) finds all of the diagnostic assurance statements to be true and 2) recommends, based on the evaluation findings, that this student be determined eligible for special education programs/services under the Cognitive Impairment Rule (R340.1705). Yes No

PARTICIPANT SIGNATURES

As a member of the Evaluation Team, my input is included in writing and I agree with the eligibility recommendation: (Sign and check below. Attach more complete statement if an Evaluation Team member checks no).

	Yes	No		Yes	No
*Psychologist _____	<input type="checkbox"/>	<input type="checkbox"/>	Other/Role _____	<input type="checkbox"/>	<input type="checkbox"/>
Other/Role _____	<input type="checkbox"/>	<input type="checkbox"/>	Other/Role _____	<input type="checkbox"/>	<input type="checkbox"/>
Other/Role _____	<input type="checkbox"/>	<input type="checkbox"/>	Other Role _____	<input type="checkbox"/>	<input type="checkbox"/>