



OCECD Parent Toolkit

INFORMATION
SHEETS



Be INFORMED.

Be EMPOWERED.

**Be your child's
ADVOCATE.**

Ohio
Coalition
for the
Education
of Children
with
Disabilities
(OCECD)

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Evaluation and Reevaluation Tips



Requesting an Initial Evaluation

A request for an initial evaluation for special education and related services (an IEP) should always be made **in writing** by you, the parents or guardians.

The school district has 30-days to respond to your request for an initial evaluation.

You should receive a written response from the school district to your request for the initial evaluation in the form of a Prior Written Notice (PR-01) which must give detailed information about how the school district came to its decision to evaluate or not evaluate.

Evaluation Planning

If the school district agrees to evaluate your child, an Evaluation Planning Meeting will be held.

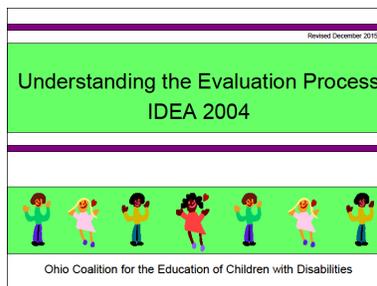
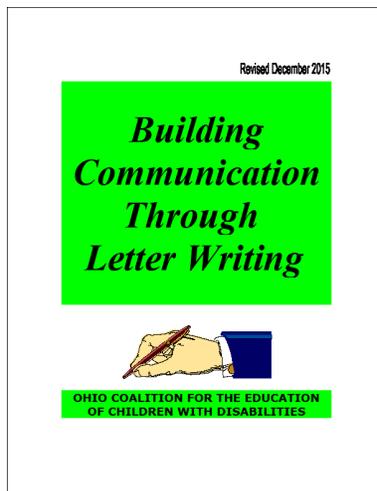
You are to be members of the evaluation planning team.

An evaluation for special education must assess your child in **all** areas related to your child's suspected disability. The evaluation planning team will identify the suspected disability(ies), the areas to be assessed, as well as the person(s) that will be conducting the assessment in each area. This information will be recorded on an evaluation planning form.

It is important to note the type of testing that will be done in each area, whether it is a simple screening or a comprehensive standardized test. A screening may be a checklist and may not provide enough information to determine the need for special education.

You will be asked to sign the evaluation planning form after it has been completed. You should request and keep a copy of the planning form.

The school district must obtain your informed, written consent before your child is evaluated.



**The initial evaluation must be completed within 60 days
from when your informed consent was obtained.**

Here is a copy of the evaluation planning form:

ETR Evaluation Team Report Planning

EVALUATION PLANNING FORM *(Required)*

School Age Disability Determination

CHILD'S NAME: _____

DATE OF PLAN: _____

ID NUMBER: _____

INITIAL EVALUATION

DATE OF BIRTH: _____

REEVALUATION

TEAM CHAIRPERSON: _____

SUSPECTED DISABILITY: _____

TEAM MEMBERS _____

ASSESSMENT AREAS RELATED TO SUSPECTED DISABILITY(IES)	DATA AVAILABLE ¹	FURTHER TESTING NEEDED ²	PERSON RESPONSIBLE FOR ASSESSMENT AND REPORT
Information Provided by Parent	<input type="checkbox"/>	<input type="checkbox"/>	
General Intelligence	<input type="checkbox"/>	<input type="checkbox"/>	
Academic Skills	<input type="checkbox"/>	<input type="checkbox"/>	
Classroom Based Evaluations and Progress in the General Curriculum	<input type="checkbox"/>	<input type="checkbox"/>	
Data from Interventions	<input type="checkbox"/>	<input type="checkbox"/>	
Communicative Status	<input type="checkbox"/>	<input type="checkbox"/>	
Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	
Social Emotional Status	<input type="checkbox"/>	<input type="checkbox"/>	
Physical Exam/General Health	<input type="checkbox"/>	<input type="checkbox"/>	
Gross Motor	<input type="checkbox"/>	<input type="checkbox"/>	
Fine Motor	<input type="checkbox"/>	<input type="checkbox"/>	
Vocational/Transition	<input type="checkbox"/>	<input type="checkbox"/>	
Background History	<input type="checkbox"/>	<input type="checkbox"/>	
Observations	<input type="checkbox"/>	<input type="checkbox"/>	
Behavior Assessment	<input type="checkbox"/>	<input type="checkbox"/>	
Adaptive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	
Other: (circle) Braille needs as determined by VI teacher or appropriately trained/licensed personnel. Audiological needs as determined by certified/licensed audiologist. Assistive Technology needs.	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	

¹ Sufficient data to determine eligibility

² Additional data required to determine eligibility. Check if further testing is needed

The Team has taken into consideration limited English proficiency to plan this assessment

The Team has taken into consideration possible sources of racial or cultural bias in planning this assessment

SIGNATURES

School District Representative (Name/ Date)

Parents (Name/ Date)

Regular Education Teacher (Name/ Date)

Intervention Specialist (Name/ Date)

