



SECTION 9

IIIPs

Individual Interagency Intervention Plan

It has been determined in 2007 that under Charter School law (Minn. Stat. § 124D.10) interagency agreements and interventions are not required. For general information regarding III-Ps, please refer to the Minnesota Department of Education TSES Manual

www.education.state.mn.us/mde/static/002312.pdf

In addition, to use III-P forms, teachers are encouraged to utilize *SpEd Forms*:

<https://spedforms.org/1000>

SAMPLE IIIP

Core Elements

Individual Interagency Intervention Plan

Required by all plans

Contents

- Demographic Information
 - Family/Student Considerations
 - Description of Child/Student
 - Shared Outcome -
- Goals/Outcomes, Objectives/Indicators, and Services**

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Individual Interagency Intervention Plan (IIIP)

CORE: Demographic Information Date _____

This plan meets the requirements of and serves as (check all that applies):

- IEP (Individualized Education Plan) IFSP (Individual Family Service Plan)
- IFCS (Individual Family Community Support Plan) ISP (Individual Service Plan)
- CADI (Community Alternatives for Disabled Individuals) Plan TBI (Traumatic Brain Injury) Plan
- CAC (Community Alternative Care) Plan Multiagency Plan of Care
- ICSP (Individual Community Support Plan) Other

Plans Coordinated Through the IIIP Process

- IPE (Individual Plan for Employment) Nursing Care Plans
- IHP (Individual Habilitation Plan) Home Care Service Plans
- ITP (Individual Treatment Plan) Out-of-Home Placement
- Corrections Other

First Name M. I. Last Name

 Male Female

Date of Birth Gender Grade Race/Ethnicity

Primary Language at Home

Soc. Sec. # MARSS ID # Other ID #

Parent/Guardian # 1's First Name M.I. Last Name

Street Address Home Phone

City State Zip Code Work Phone

Relationship Email Other

Parent/Guardian # 2's First Name M.I. Last Name

Street Address Home Phone

City State Zip Code Work Phone

Relationship Email Other

Resident School District Name District #

Serving School District Name District #

Resident County Name County #

Serving County Name County #

(Initial IIIP only) Referral by Date of Referral

Primary Disability Diagnosis Code: DSM-IV or ICD 9

Presenting concerns and/or diagnosis:

If you ask, we will provide this form in another format, such as Braille, large print or audio tape.

Individual Interagency Intervention Plan (IIIP)

CORE: Family/Student Considerations

Name Date

IIIP Meeting Date

Projected IIIP Review Date

Parent(s) description of child/student's strengths and concerns/needs:

Student description of needs, preferences and interests (by age 14 or earlier, if appropriate):

Services or information needed by family and/or student:

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Individual Interagency Intervention Plan (IIIP)

CORE: Description of Child/Student

Name Date

Address the following areas as required. For children ages three through 21, describe how the disability affects involvement and progress in the general curriculum. For preschool children, describe how the disability affects participation in appropriate activities. Describe how the disability impacts secondary transition planning. (*Required for ages birth to three. **Required for transition planning ages 14-21.)

- *Current Health & Medical Status Adaptive Development
- *Physical/Motor Development **Community Access/Use/Participation
- *Basic Senses Including Hearing & Vision Legal Representation
- *Academic Performance/Cognitive Development/Intellectual Functioning **Employment
- *Social/Emotional/Behavioral Development **Home Living
- *Communication **Recreation and Leisure
- Environmental (Basic Needs) **Postsecondary Education and Training
- Other *Self-Help Skills

Area _____

Strengths/Current Status _____

Concerns/Needs _____

Area _____

Strengths/Current Status _____

Concerns/Needs _____

Area _____

Strengths/Current Status _____

Concerns/Needs _____

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Service Minutes/Session: Direct Indirect
Service Location Frequency (#/wk, #/mo)
Agency Providing Service Start Date Duration
Service Provider Name Telephone
Address City State Zip
1. Payment Source Authorizing Signature
2. Payment Source Authorizing Signature
3. Payment Source Authorizing Signature
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Individual Interagency Intervention Plan (IIIP) CORE: Shared Outcome— Goals/Outcomes, Objectives/Indicators, and Services

Name: Date:

Shared Outcome:

Goal:

Objective:

Goal:

Objective:

This plan must specify services the person needs that are not available and the actions needed to obtain or develop these services. Action taken, if needed:

Service Minutes/Session: Direct Indirect
Service Location Frequency (#/wk, #/mo)
Agency Providing Service Start Date Duration
Service Provider Name Telephone
Address City State Zip
1. Payment Source Authorizing Signature
2. Payment Source Authorizing Signature
3. Payment Source Authorizing Signature

Goal:

Objective:

Service Minutes/Session: Direct Indirect
Service Location Frequency (#/wk, #/mo)
Agency Providing Service Start Date Duration
Service Provider Name Telephone
Address City State Zip
1. Payment Source Authorizing Signature
2. Payment Source Authorizing Signature
3. Payment Source Authorizing Signature

Individual Interagency Intervention Plan Required by specific plans

Contents

- Additional Information Required for Birth to Three
- Additional Information Required for Three through Twenty-one
- Periodic Review Required for Ages Birth to Three
- High Standards Required for Ages Three to Graduation from High School
- Profile of Learning Chart for IEP Planning - Primary Grades
- Profile of Learning Chart for IEP Planning - Intermediate Grades
- Profile of Learning Chart for IEP Planning - Middle Grades
- Profile of Learning Chart for IEP Planning - High School Grades
- Signatures Required for ISP (Individualized Service Plan), IFSP (Individual Family Service Plan) and Waiver Care Plans
- Signatures, IF REQUIRED, and Designee Assignments
- Signatures Required for Medical Assistance Waiver Care Plans (CAC, CADI, and TBI)

Additional Required Elements Individual Interagency Intervention Plan (IIIP)

Additional Information Required for Ages Three through Twenty-one

Name Date

Federal Setting # _____

Progress Reporting

Frequency and method(s) to be used for reporting to parents:

Adaptations

Adaptations needed, including: 1) supplemental aids and services in general and special education; 2) program modifications or supports for school personnel to meet the needs of the students; and 3) assistive technology: *(See Optional Forms for Adaptation Checklist)*

Least Restrictive Environment (LRE)/Most Integrated Setting Explanation

If the student is not able to participate full-time with students without disabilities in the regular classroom and/or in extra-curricular and non-academic activities, explain the extent of non-participation and reasons for this non-participation:

Extended School Year (ESY)

Are extended school year services required for this student? Yes No More data needed

If yes, services are described within this plan or in attached documentation.

Transfer of Rights at Age of Majority

Addressed only in IEPs for students who will reach age 17 during the tenure of this IIIP. Prior to the student's 17th birthday, the student was informed of the rights that will transfer to him/her upon reaching the age of majority (18), unless a legal guardian or conservator has been appointed.

Date student was informed

Secondary Transition Planning

Transition Needs: For students about to enter grade 9 or reach age 14 and thereafter, describe the focus of courses of study to address transition needs from secondary services to postsecondary:

Transition Services: For students about to enter grade 9 or reach age 14 and thereafter, identify instructional services, related services, and interagency responsibilities and any needed linkages to address transition from secondary services to postsecondary education and training, employment, community participation, recreation and leisure, and home living, and the person(s) accountable for each activity:

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Individual Interagency Intervention Plan (IIIP) High Standards Required for Ages Three to Graduation from High School

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Prepared by *Designs for Learning* Staff

Name Date

Minnesota Comprehensive Assessment Basic Standards Assessment

Address for MCA's administered during the student's annual IEP year.

- Will participate without accommodations
- Will participate with accommodations listed:
(Modifications are not allowed.)
- Exempt; state reason and when alternate assessment will be conducted:

Address for BSA's administered during the student's annual IEP year.

- Will participate without accommodations or modifications
- Will participate with accommodations listed:
- Will participate with modifications listed:
- Exempt; state reason:

State Individual* Exempt**

Reading

Math

Writing

Date Passed

Check the appropriate box to indicate the level the student will attempt.

*If the modification is to alter the district's passing level, enter the test score expected to be achieved. **If the student is exempt, the goals on the IEP will be the criteria for awarding the diploma.

District Initiated System Assessment

Address each time a student is in a grade being assessed by the district

- Will participate without accommodations
- Will participate with accommodations listed:
- Exempt; reason and alternative assessments listed:

Profile of Learning/High Standards and/or Minnesota Academic Standards

Will participate in the Profile of Learning High Standards. See attached documentation and identify local requirements.
(Based

on existing locally established requirements.) and/or

- Will participate in the Minnesota Academic Standards as they are written. No changes will be made.
- The IEP team has determined that some of the Minnesota Academic Standards are inappropriate. Some or all of student's IEP

goals and objectives will replace the inappropriate academic standard(s) listed below. *(List inappropriate standards here.)*

The IEP team has determined that, because of the nature of the child's disability, all of the Minnesota Academic Standards are inappropriate. The student's IEP goals and objectives will be the established alternative standard(s).

Individual Interagency Intervention Plan (IIIP)

**Signatures Required for ISP (Individualized Service Plan),
IFSP (Individualized Family Service Plan) and Waiver Care Plans**

Name Date

Parent/Guardian Signatures:

When you sign this form, it means that you have read or have had this Interagency Individual Intervention Plan (IIIP) read to you. Signing this document means you agree with the goals and services for your family and your child/student as written in this plan. It is important that you know you have the right not to sign this plan if you do not agree with it in its entirety.

Signature Relationship to Child/Student

Signature Relationship to Child/Student

I/We have also been informed of my/our right to request a conciliation conference or an administrative appeal for county developmental disability case management and related services.

Signature Relationship to Child/Student

Signature Relationship to Child/Student

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County or Other Case Manager

Physician or Other Health Care Professional

Other

Designee Assignments:

IIIP Coordinator

Name Position

Agency Telephone

IEP Manager

Name Position

Agency Telephone

Multi-agency Plan of Care

Name Position

Agency Telephone

Individual Interagency Intervention Plan (IIIP)

Name Date

Signatures, IF REQUIRED, and Designee Assignments

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Signatures, IF REQUIRED

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Individual Interagency Intervention Plan (IIIP)

Signatures Required for Medical Assistance Waiver Care Plans (CAC, CADI, and TBI)

Name Date

Service Span Start Date Service Span End Date PMI#

Case Mix Classification

Clients Rights and Signatures

- A. Yes No I was offered a choice of home and community-based care, nursing facility or hospital placement.
- B. Yes No I was offered a choice of home and community-based services.
- C. Yes No I was offered a choice of providers.
- D. Yes No NA I have read and understand each of the rights and responsibilities stated on the application for home and community-based services, including my right to appeal.
- E. Yes No I have read the Individual Care Plan and agree with it.

Check One

F. I agree with my care plan.

G. I agree with most of my care plan and want community services.

H.. I agree with most of my care plan but wish to discuss the plan further before initiating or changing community services.

Client/Legal Guardian Signature Date

Client/Legal Guardian Signature (Reassessments only) Date

Signature of person completing this plan (Reassessments only) Date

Approval by county of Medicaid responsibility if different from county of service Date

Date care plan was mailed/given to applicant