

Collaborative Assessment of Student Performance

TAP Staff, please complete this document within 60 days from date of intake and provide to the IVRS Counselor for assistance with completing eligibility determination.

Name of School Staff: _____ Name of AEA Rep: _____

Student Name: _____ School Name: _____

Please check one box in each section below.

1. Identification for Special Education Services (other than speech only or PT/ OT only) occurred:
 - Pre-K, Kindergarten, or 1st Grade
 - 2nd Grade, 3rd Grade, or above
2. Curriculum:
 - Participates in the general curriculum at a level similar to peers.
 - Curriculum reflects a downward extension of standards and benchmarks or curriculum is modified substantially to allow for extensive adaptive instruction.
3. Goals/ Support:
 - Goals are academic and based on district standards and grade level benchmarks.
 - Goals are based on district standards and benchmarks are extended to meet individual needs.

Academic Achievement/ Present Level of Educational Performance

Skill Area	Functioning Grade Level	Assessment Methods	Date Completed
Mathematics			
Written Language			
Reading			

Summary of Functional Limitations

Please check functional areas considered to be serious limitations. Please describe extent of limitations.

MOBILITY:

- | | | |
|-----------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Balancing | <input type="checkbox"/> Climbing |
| <input type="checkbox"/> Stooping | <input type="checkbox"/> Twisting | <input type="checkbox"/> Travel |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> Crawling | <input type="checkbox"/> Crouching |
| <input type="checkbox"/> Other: | | |

Description:

SELF CARE:

- | | | |
|----------------------------------|---|--|
| <input type="checkbox"/> Eating | <input type="checkbox"/> Independent Living | <input type="checkbox"/> Dressing |
| <input type="checkbox"/> Laundry | <input type="checkbox"/> Child Care | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Toileting | <input type="checkbox"/> Money Management |

Using the Telephone

Self-Injurious Behavior

Other:

Description:

Hygiene

Housekeeping

Grooming

Repeat Hospitalization

SELF DIRECTION:

Dependability

Being Punctual

Initiating Activities

Other:

Description:

Judgment

Being Organized

Planning Activities

Frequent Changes

Following Routine

Making Decisions

WORK SKILLS:

Eye/Hand Coordination

Manipulates Objects

Comprehension

Spatial/Time Management

Other:

Description:

Learning Speed

Manual Dexterity

Memory

Motor Coordination

Attention Span

Quantitative Skills

WORK TOLERANCE:

Temperature Change

Chemical Sensitivity

High Places

Psychological Factors

Wet/Humid Environment

Noise/Vibrations

Absenteeism

Standing

Lifting

Work Speed

Reaching

Cold/Heat

Stress

Strength

Stamina

Fumes/Dust

Sitting

Other:

Description:

INTERPERSONAL SKILLS:

Controlling Emotions

Getting Along With Others

Social Withdrawal

Cooperation

Understanding Social Cues

Accepting Supervision

Tact/Diplomacy

Other:

Description:

COMMUNICATION:

Interviewing

Reading

Writing

Speaking

Hearing

Other:

Description:

School Staff Signature: _____

Date: _____

AEA Rep Signature: _____

Date: _____

TAP Signature: _____

Date: _____