Wayne County Initial Student Assistance Team (SAT) Report

Meeting Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please Complete This at the Initial SAT Meeting and Give a Copy to the Guardian*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Student’s Name School WVEIS DOB

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Teacher/Grade Teacher Email Parent/Guardian

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Address City Zip

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| **Does this student have a current IEP? \_\_\_\_ Yes \_\_\_\_\_ No, If yes, please refer to student’s case manager and complete a re-evaluation plan!**  List contacts made prior to this SAT meeting in order to invite guardians (at least 3 attempts if no response).  **Date Phone Mail Personal Description of Results of Contact**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |   Based on the referral, identify goals for the student. Be sure they are SMART goals (Specific, Measurable, Achievable, Relevant, and Timely). |
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| Clearly and explicitly define the problem the student is having in the classroom that is keeping him/her from achieving above mentioned goals (ex: excessive absences, off task behavior, not turning in assignments, difficulty reading). |
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| Please list the assessments and data used to determine the student’s current level of achievement to help guide development of intervention strategies. **Attach these reports** (i.e. Benchmark data, progress monitoring, classroom work, statewide test scores, discipline reports etc.). |
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What are possible causes the student is exhibiting this problem (e.g. Why are they consistently absent, why are they off task, why are they not turning in assignment, why are they having reading difficulty)?

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Brainstorm possible ideas that will help the student progress toward the goal to make them successful in the classroom. Choose from this list to begin development of intervention plan.

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**Initial Intervention Plan**

*Interventions are small group or individualized instruction on a specific skill based on student’s current ability.*

**Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Meeting Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- |
| **Learning or Behavior Concern**  **Goal:** | **Intervention Implemented:**  **#Sessions/week\_\_\_\_\_\_ Length of session \_\_\_\_Min**  **Date Initiated**  **Person Responsible:** |
|  |  |
| **Learning or Behavior Concern**  **Goal:** | **Intervention implemented:**  **#Sessions/week\_\_\_\_\_\_ Length of session \_\_\_\_Min**  **Date Initiated**  **Person Responsible:** |
|  |  |
| **Learning or Behavior Concern**  **Goal:** | **Intervention Implemented:**  **#Sessions/week\_\_\_\_\_\_ Length of session \_\_\_\_Min**  **Date Initiated**  **Person Responsible:** |

**\*\*\*\*referral documentation must include 9 weeks of TARGETED INTERVENTION (3-5X/WK, 15-30 MIN/EACH) AND 9 WEEKS OF INTENSIVE INTERVENTION (3-5X/WK, 30-60 MIN/EACH) AND 6 PROGRESS MONITORING DATA POINTS\*\*\*\***

Outcome of Initial SAT meeting:

* The SAT will implement interventions and will reconvene within **45 school days** to review results of interventions. Date for review meeting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* The SAT will implement the interventions, but feels a multidisciplinary evaluation is necessary to determine a need for special education services. Please see what is required for an evaluation referral.
* The SAT will implement interventions, but will refer for a 504

**if option 2 is chosen, Consultation with Wayne county office of special programs staff is encouraged during the mdet process.**

**As a result of choosing option 2 the following have been provided to the parent on the following date \_\_\_\_\_\_\_\_**

**\_\_\_\_ Notice of evaluation**

**\_\_\_\_ Procedural Safeguards**

**\_\_\_\_ Prior Written notice**

**Confidentiality Statement: Signatures indicate participation in the meeting where above interventions were developed. Signatures also indicate all information shared at this SAT meeting must remain confidential, within the confines of professional duties or as mandated by law, and cannot be shared with anyone without a signed release from the child’s guardian.**

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**Administrator or Designee (Required) Date Guardian (Required to Invite) Date**

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**Current Teacher (Required) Date Member (1 Other Member Required) Date**

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**Member Date Member Date**