**RURAL CHAMPAIGN COUNTY SPECIAL EDUCATION COOPERATIVE**

***Documentation of Need for Teaching Assistant Support***

***(Form required when considering aid support)***

**IDEA** is not specific with regard to the assignment of a one-to-one, classroom, or program aide for students with disabilities. Rather, an aide is identified in the law as a “supplementary aid or service.” Supplementary aides and services are “aides, services, and other supports that are provided in regular education classes, other education-related settings, and in extracurricular and nonacademic settings, to enable children with disabilities to be educated with nondisabled children to the maximum extent appropriate.” 34 C.F.R. 300.42.

**Possible ADVERSE EFFECTS of Paraprofessional Support:** Separation from classmates, dependence on adults, learned helplessness, impact on peer interactions, limitations on receiving certified/qualified instruction, loss of personal control, interference with instruction for other students, interference with ownership and responsibility by general educators

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| **GENERAL INFORMATION** |
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| Requestor(s) Name:  |   | Date of Request: | Click here to enter text. |
| Students Name: | Click here to enter text. | Date of Birth: | Click here to enter text. |
| *(If request is for a classroom aide, student name may not be needed unless request relates to only one child in the classroom.)* |

Reason(s) For Request:  |
|[ ]  Self-Care Assistance (Complete Sections 1,4 & 5) |
|[ ]  Medical Assistance (Complete Sections 2, 4 & 5) |
|[ ]  Safety/Protection (Complete Sections 3, 4 & 5) |
|[ ]  Instructional Support (Complete Sections 4 & 5) |

*Comment boxes are expandable. When typing in a comment box, you can add another line by hitting Shift Enter.*

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| **SECTION 1 – SELF-CARE ASSISTANCE** |

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| 1. **Mark items the student is unable to perform independently.**

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|[ ]  Toileting |
|  |[ ]  Student is not toilet trained. |
|  |[ ]  Student is toilet trained, but requires assistance with self-care. |
|  |[ ]  Student requires assistance to be lifted onto toilet. |
|  |[ ]  Other (describe) Click here to enter text. |
| List times of day when toileting assistance is needed: Click here to enter text.  |

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|[ ]  Mobility |
|  |[ ]  Student is in wheelchair. |
|  |[ ]  Student is blind and unable to navigate independently. |
|  |[ ]  Other (describe) Click here to enter text. |
| List times of day when mobility assistance is needed: Click here to enter text. List activities when mobility assistance is needed: Click here to enter text.  |
|[ ]  Feeding |
|  |[ ]  Student is unable to feed self. |
|  |[ ]  Student has feeding tube. |
|  |[ ]  Student requires prompting to feed self. |
|  |[ ]  Other (describe) Click here to enter text. |
| List times of day when feeding assistance is needed: Click here to enter text.  |
|[ ]  Dressing |
|  |[ ]  Student is unable to pull up pants when using restroom. |
|  |[ ]  Student is unable to put on or take off own clothing. |
|  |[ ]  Other (describe) Click here to enter text. |
| List times of day when dressing assistance is needed: Click here to enter text.  List activities when dressing assistance is needed: Click here to enter text.  |
|[ ]  Following basic safety rules (due to low cognitive ability) |
|  |[ ]  Student wanders away from school personnel. |
|  |[ ]  Student places inedible object in mouth (to degree of being a safety concern) |
|  |[ ]  Other (describe) Click here to enter text. |
| List times of day when basic safety assistance is needed: Click here to enter text.  List activities when basic safety assistance is needed: Click here to enter text.  |

1. **Can the students self-care needs be met with the use of accommodations and modifications?** [ ] **Yes** [ ] **No**

***If “No,” list accommodations and modifications attempted:*** Click here to enter text.***If “Yes”, the student DOES NOT require aide support in this area.*****C. The student requires aid support to be involved in and make progress in the general education curriculum.** [ ] **Yes** [ ] **No** |
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| **SECTION 2 – MEDICAL ASSISTANCE** |

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| 1. **Describe student health concern(s):**

Click here to enter text.1. **Describe medical assistance needed:**

Click here to enter text.1. **Are medical needs able to be addressed by school nurse?** [ ] **Yes** [ ] **No**

**If “No,” explain why:**Click here to enter text.1. **Has the student previously required the services of a Health Aide?** [ ] **Yes** [ ] **No**
2. **Is the current Health Aide provided by the District?** [ ] **Yes** [ ] **No** [ ] **N/A**

**If “No,” explain:**Click here to enter text.1. **List times of day and activities when medical assistance, other than that provided by school nurse, is needed:**

Click here to enter text.1. **Can the students medical needs be met through the use of accommodations and modifications?** [ ] **Yes** [ ] **No**

**If “No,” list accommodations and modifications attempted:**Click here to enter text.***If “Yes”, the student DOES NOT require aide support in this area.*****C. The student requires aid support to be involved in and make progress in the general education curriculum.** [ ] **Yes** [ ] **No** |

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| **SECTION 3 – SAFETY/PROTECTION** |

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| 1. **Student is a safety threat to self:** [ ] **Yes** [ ] **No If “Yes,” explain (include description of frequency, duration, intensity, and location of behaviors):**

Click here to enter text.1. **Student is a safety threat to others:** [ ] **Yes** [ ] **No If “Yes,” explain (include description of frequency, duration, intensity, and location of behaviors):**

Click here to enter text.1. **Student requires supervision during unstructured times:** [ ] **Yes** [ ] **No If “Yes,” explain (include description of frequency, duration, intensity, and location of behaviors):**

Click here to enter text.1. **Functional analysis and behavior intervention plan completed?** [ ] **Yes** [ ] **No**
2. **Can the students safety needs be met through the use of accommodations, modifications and behavior intervention plan?** [ ] **Yes** [ ] **No**

***If “No,” list accommodations and modifications attempted:***Click here to enter text.***If “Yes”, the student DOES NOT require aide support in this area.*****C. The student requires aid support to be involved in and make progress in the general education curriculum.** [ ] **Yes** [ ] **No** |

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| **SECTION 4 – INSTRUCTION** |

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| 1. **Request is for Classroom Aide?** [ ] **Yes** [ ] **No**

***What accommodations and/or modifications have been tried? If none, aide assistance will not be considered at this point.*** Click here to enter text.***Has an observation been conducted? If no, aide assistance will not be considered at this point.*** Click here to enter text.

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|[ ]  Class exceeds allowable class size requirement |
|  |[ ]  Per ISBE guidelines |
|  |[ ]  Per District Special Educator Workload Plan |
| List class title and time of class: Click here to enter text.  |
|[ ]  Nature and severity of student needs in classroom |
| List class title and time of class: Click here to enter text.  |
| Explain:Click here to enter text.  |
|[ ]  Individual student requires classroom aide support in order to participate in general education environment. |
| List class title and time of class: Click here to enter text.  |
| Explain:Click here to enter text. List the functional, behavioral, academic deficits noted on the most recent evaluation. Please include the date of the evaluation.Click here to enter text.How is the student’s deficit significantly different from the needs of typical peers and of an intensity or type that it requires aide assistance?Click here to enter text. |

1. **Request is for Individual Aide?** [ ] **Yes** [ ] **No**

***What accommodations and/or modifications have been tried? If none, aide assistance will not be considered at this point.*** Click here to enter text.***Has an observation been conducted? If no, aide assistance will not be considered at this point.*** Click here to enter text.

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|[ ]  Student has significant academic delays and progress cannot be achieved with the use of accommodations and modifications only; |
| Explain:Click here to enter text. List the functional, behavioral, academic deficits noted on the most recent evaluation. Please include the date of the evaluation.Click here to enter text.How is the student’s deficit significantly different from the needs of typical peers and of an intensity or type that it requires aide assistance?Click here to enter text. |
|[ ]  Student has significant deficits in on-task behavior: |
| Click here to enter text. | Percentage of time student is off-task during instruction. |
| Click here to enter text. | Percentage of time student is off-task during independent work. |

How does the student’s behavior impede learning or that of others?Click here to enter text.1. **Describe the proposed plan of support. (Include a description classes, non-academic settings, type of support, and expected outcomes)**

Click here to enter text. |

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| **SECTION 5 – PLAN FOR STUDENT INDEPENDENCE** |

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| 1. **Describe the proposed plan for reducing aide time and fostering student independence including the corresponding IEP goal number(s)**

Click here to enter text. |
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**Considering all the above information, the IEP team recommends:**

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|  |[ ]  The student does not need access to aide assistance. |
|  |[ ]  The student should have access to a program aide assistant. |
|  |[ ]  The student requires one-to one aide assistance (identify times of day) |
|  |  | Click here to enter text. |