

**Illinois Statewide Technical Assistance Center (ISTAC)
Systematic Information Management for Educational Outcomes (SIMEO)
Student Disposition Tool (SD-T): FY09**

Facilitator is REQUIRED to complete the following tracking information every time data are collected:

Time 1/Baseline	Time 2	Time 3	Time 4
Collected no later than 30 days from referral and before first meeting	Collected anywhere from a maximum of monthly from the point of initial assessment to a minimum of once at three months following initial assessment, or before the school year ends	Collected anywhere from a maximum of monthly from the point of Time 2 assessment to a minimum of once at six months following initial assessment, or before the school year ends	Collected anywhere from a maximum of monthly from the point of Time 3 assessment to a minimum of once at 9 months after initial meeting, or before the school year ends

- 1) Date Completed: _____
- 2) Student Name: _____ 3) Student ID: _____
- 4) Please identify the period of assessment:
- Time 1/Baseline Time 2 Time 3 Time 4 Time 5 Time 6
 Time 7 Time 8 Time 9 Time 10 Discharge
- 5) This tool was filled out by: an individual a team
- 6) If an individual, indicate role: Parent/Caregiver Teacher Wrap Facilitator Family Focus Facilitator-Autism
 Social Worker Guidance Counselor PBIS Coach
 Other _____
- 7) Please identify all ISTAC Initiatives involved with this student and family:
- CHOICES IATTP ISRC PBIS Other
- 8) If PBIS, is this tool being filled out as: part of a secondary intervention or simple FBA
 part of an individual intervention or complex FBA part of a wraparound process

SECTION 1: Fill out at time of referral

- 9) Date of referral: _____ 10) Name of person making referral: _____
- 11) Phone: _____ 12) Email: _____
- 13) Job Title: Parent Special Ed Director TA Specialist Agency Social Worker
 Teacher Case Manager PBIS Coach Behavior Consultant
 Principal Resource Teacher School Social Worker Therapist
 ISTAC Coordinator/Team Member School Psychologist
Other: _____
- 14) Name of individual entering SIMEO data into database: _____
- 15) Quarter: One (July 1-Sept. 30) Two (Oct 1-December 31) Three (January 1- March 31) Four (April 1-June 30)
- 16) State Fiscal Year _____
- 17) Date of Initial Conversation with Parent/Guardian _____ 18) Anticipated Date of First Team Mtg _____
- 19) Name of Person Facilitating Team and Individualized Plan: _____
- 20) Phone: _____ 21) Email: _____
- 22) Job Title: Parent Special Ed Director TA Specialist Agency Social Worker
 Teacher Case Manager ISTAC Coordinator/Team Member Behavior Consultant
 Principal Resource Teacher School Social Worker Therapist
 Family Focus Facilitator-Autism School Psychologist PBIS Coach
 Other:

(PBIS Only) External Coach to School

- 23) Is there an identified external coach for this school? Yes No
- 24) Name: _____
- 25) Phone: _____ 26) Email: _____

Demographics of School Student Attends

- 27) School Name _____ 28) District Number: _____
- 29) Special Education Coop (if applicable): _____ 30) County: _____
- 31) School Address: _____ City/State: _____ Zip: _____
- 32) Contact: _____ 33) Phone: _____
- 34) Is this student in a PBIS school? Yes No
- 35) Grade: 0-3 Services K 2 4 6 8 10 12 Drop-Out Post 12 Transition
 Pre-K 1 3 5 7 9 11 Not Enrolled Home Schooling

SECTION 2: Fill out during all rating periods (baseline, quarterly, and discharge) unless otherwise indicated.

- 36) Is this student currently identified as a special education student with an IEP? Yes No
- 37 and 38) Please select disabilities as Identified on IEP: (Please indicate primary disability with 1 and secondary disability with 2)
- | | | |
|-------------------------------|---------------------------------------|-----------------------------|
| _____ Mental Retardation | _____ Hearing Impairment | _____ Emotional Disturbance |
| _____ Visual Impairment | _____ Speech &/or Language Impairment | _____ Developmental Delay |
| _____ Deafness | _____ Multiple Disabilities | _____ No Disability |
| _____ Other Health Impairment | _____ Traumatic Brain Injury | _____ 504 Plan |
| _____ Autism | _____ Specific Learning Disability | |
| _____ Orthopedic Impairment | _____ Deaf-Blind | |
- 39) (IATTP Only) Please identify the DSM diagnosis of the student (only one per student):
- Childhood Disintegrative Disorder Rett Disorder PDD/NOS Asperger Disorder Autism
- Other (please specify) _____

- 40) The current educational placement is:
- General ed classroom 100% of the day-FACTS Code 01
 - General ed classroom with special ed consultation-FACTS Code 01
 - General ed classroom with inclusion support-FACTS Code 01
 - Special ed instruction and/or related services 1-20% of the day OUTSIDE the general ed classroom-FACTS Code 01
 - Special ed instruction and/or related services 21-60% of the day OUTSIDE the general ed classroom-FACTS Code 02
 - Special ed instruction and/or related services more than 60% of the day OUTSIDE general ed-FACTS Code 03
 - Special ed 100% in a separate public day school-FACTS Code 04
 - Special ed 100% in a separate public day school in conjunction with a separate residential component-FACTS Code 05
 - County or municipal detention center or jail-FACTS Code 07
 - IYC – Jail-FACTS Code 07
 - Private day school-FACTS Code 08
 - Private residential-FACTS Code 09
 - Alternative education setting
 - Homebound-FACTS Code 11
 - Hospital-FACTS Code 12
 - Regular education Pre-school
 - Special education Pre-school/Early Childhood
 - Community Child Care
 - Partial Day School
 - Other _____

- 41) Has educational placement changed in the past three months? Yes No
- 42) (ISRC Only) Has a Home School Team been established? Yes No Not applicable

Student Demographics

- 43) Caregiver primary language: English Spanish Chinese French German Other: _____
- 44) Caregiver relationship to student: Mother Father Grandparent Step-parent Foster Parent Two Parents
 Other Relative Other: _____
- 45) Student race: Asian African-American Biracial Caucasian Hispanic/Latino Other: _____

SECTION 2 (cont) Review Assessment: Fill out during all rating periods following time of referral (quarterly and discharge)

46) Student Gender: Male Female

47) Student DOB: _____

48) Student Age: _____

49) LAN # of LAN where student resides: _____

50) Has this student been referred for support through their LAN?

51) If yes, have flexible funds been requested? Yes No

52) Student primary language: English Spanish Chinese French German Other: _____

53) Are there other agencies currently involved with the student and/or family? Yes No

54) If yes, indicate agencies currently involved: DCFS Probation CMHC Public Aid Other: _____

55) Does this student have DCFS legal involvement? Yes No

56) (ISRC only) Does student have cochlear implant? Yes No Not applicable

57) How many student/family team meetings were held since last SIMEO review or assessment, to include baseline? _____

58) (PBIS only) Were SWISS data used in any student/family meetings during the reporting period? Yes No

59) Were SIMEO data used in any student/family meetings during the reporting period? Yes No

60) If yes, please indicate how data were used (check as many as apply):

- to engage team members to ensure voice of family to design interventions
 to revise actions of team to celebrate success data not used

61) Does student have a BIP? Yes No Not applicable

62) If student is enrolled in grade 3-8 or 11 (or the educational equivalent) this year, will they be participating in ISBE State Performance Testing? Yes No

63) If yes, please identify the Performance test taken or to be taken by the student: ISAT IAA Other: _____

64) If the student has taken the State performance test since the last RD-T assessment, please identify the student's score:

- Exceeded Standards Met Standards Below Standards Academic Warning
 Did not take test within this assessment period

School Related Risk Factors: Fill out during all rating periods (baseline, quarterly, and discharge).

65) Risk of failure in home placement: no risk minimal risk moderate risk high risk

66) Risk of failure in school placement: no risk minimal risk moderate risk high risk

67) Risk of failure in community placement: no risk minimal risk moderate risk high risk

68) Has the student had any disciplinary referrals in the past three months? Yes No 69) If so, how many? _____

70) Has the student received any in-school suspensions in the past three months? Yes No 71) If so, how many? _____

72) Has the student received any out-of-school suspensions in the past three months? Yes No 73) If so, how many? _____

74) Has the student received any expulsions in the past three months? Yes No 75) If so, how many? _____

Other School Related Risk Factors: Fill out during all rating periods following time of referral (quarterly and discharge).

76) School attendance: 59% or below 60-69% 70-79% 80-89% 90-100%

77) Please rate the approximate Grade Point Average of the student:

- 59% or below 60-69% 70-79% 80-89% 90-100% Not applicable

78) Has student dropped out of school? Yes No

79) Has student graduated from High School? Yes No 80) Date student graduated: _____

81) If graduated, with what? High School Diploma Certificate GED

82) Have the individualized supports and services through the ISTAC Initiative diverted the student from a more restrictive placement?

- Yes No Not applicable-Baseline

83) Has the student been discharged from the ISTAC Initiative this semester? Yes No

SECTION 2 (cont) Review Assessment: Fill out during all rating periods following time of referral (quarterly and discharge)

84) If yes, please identify reason for discharge:

- success completion of Initiative student transition (moved, changed schools or district) student graduated
 team dissolved student/parent opted out
 other: _____

85) If yes, please rate the overall success of the ISTAC Initiative (Discharge only):

- Poor Unsatisfactory Satisfactory Above Average Excellent

SECTION 3 Services Provided through Individualized Plan

86-89) Services Utilized: Fill out during all rating periods following time of referral.

Please check if services are currently being utilized and in the spaces provided please use the following codes to rate frequency and duration of services.

Frequency Scale: 1 = 1 time in the last 3 months 2 = 1 time per month 3 = 1 time per week
 4 = More than 1 time per week 5 = 1 time per day 6 = More than 1 time per day

Duration Scale: Please use a numeric value (number) to reflect the number of units (hours) of service the student received during the identified frequency period. For example, if the student received 6 hours of discrete trial format- applied behavioral analysis teaching, two times per week the numeric rating for frequency would be 4 and the numeric rating for duration would be 6.

Home

Fam	Chld		Frequency	Duration			Frequency	Duration	
<input type="checkbox"/>	<input type="checkbox"/>	Child Care	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	In-Home Services	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child Protective Services	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Individual Aide	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Counseling - Couples	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Medical Services	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Counseling - Group	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Medicare Services	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Counseling - Individual	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Medication	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Counseling – Substance Abuse	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Medication Evaluation	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Domestic Violence Intervention	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Assessment	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Employment Assistance	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Mentoring	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Financial Support	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Parenting Education	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Homemaking Services	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Parent Supports	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Pre-natal Care	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Housing Assistance	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Public Aid/TANF	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Recreation Plan	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Transportation	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Respite	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Vocational Training	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Service Coord./Case Mgmt.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	Personal Assistant	_____	_____
					<input type="checkbox"/>		Other _____		

School

Chld		Frequency	Duration			Frequency	Duration
<input type="checkbox"/>	Academic Interventions	_____	_____	<input type="checkbox"/>	Occupational Therapy	_____	_____
<input type="checkbox"/>	Academic Tutoring	_____	_____	<input type="checkbox"/>	Orientation and Mobility Services	_____	_____
<input type="checkbox"/>	After School Program	_____	_____	<input type="checkbox"/>	Personal Assistant/Aide or Individual Aide	_____	_____
<input type="checkbox"/>	Anger Management Interventions	_____	_____	<input type="checkbox"/>	Peer Mentor	_____	_____
<input type="checkbox"/>	Assistive Technology Services or Devices – Low Tech	_____	_____	<input type="checkbox"/>	Peer Support Strategies	_____	_____
<input type="checkbox"/>	Assistive Technology Services or Devices – High Tech	_____	_____	<input type="checkbox"/>	Physical Therapy	_____	_____
<input type="checkbox"/>	Audiology Services	_____	_____	<input type="checkbox"/>	Reader or Interpreter	_____	_____
<input type="checkbox"/>	Auditory Integration Therapy	_____	_____	<input type="checkbox"/>	Recreation Therapy	_____	_____
<input type="checkbox"/>	Case Management Services	_____	_____	<input type="checkbox"/>	Nursing Care	_____	_____
<input type="checkbox"/>	Child Care	_____	_____	<input type="checkbox"/>	Relaxation & Self-Modulation Training	_____	_____
<input type="checkbox"/>	Counseling - Group	_____	_____	<input type="checkbox"/>	Social Skills Instruction	_____	_____
<input type="checkbox"/>	Counseling - Individual	_____	_____	<input type="checkbox"/>	Sensory Plan	_____	_____

School con't

Child	Frequency	Duration		Frequency	Duration
<input type="checkbox"/> Crisis/Safety Plan	_____	_____	<input type="checkbox"/> Special Education Referral	_____	_____
<input type="checkbox"/> Curriculum Modification	_____	_____	<input type="checkbox"/> Speech and Language Therapy	_____	_____
<input type="checkbox"/> Discrete Trial Format or Applied Behavioral Analysis teaching	_____	_____	<input type="checkbox"/> Substance Abuse Treatment	_____	_____
<input type="checkbox"/> FBA/BIP	_____	_____	<input type="checkbox"/> Summer School Program-Not part of IEP	_____	_____
<input type="checkbox"/> Functional Curriculum	_____	_____	<input type="checkbox"/> Transition Planning	_____	_____
<input type="checkbox"/> Language Training	_____	_____	<input type="checkbox"/> Visual Communication Systems	_____	_____
<input type="checkbox"/> Leisure and Community Training	_____	_____	<input type="checkbox"/> Visual Environment Supports	_____	_____
<input type="checkbox"/> Life Skills Instruction	_____	_____	<input type="checkbox"/> Vocational Assessment	_____	_____
<input type="checkbox"/> Medication	_____	_____	<input type="checkbox"/> Vocational/Post-Secondary Planning	_____	_____
<input type="checkbox"/> Medication Evaluation	_____	_____	<input type="checkbox"/> ESY-As part of IEP	_____	_____
<input type="checkbox"/> Mentor/Advocate	_____	_____	<input type="checkbox"/> Other:	_____	_____
<input type="checkbox"/> Motor Skills Therapy	_____	_____	_____	_____	_____
<input type="checkbox"/> Nursing Care	_____	_____	<input type="checkbox"/> Other	_____	_____
			_____	_____	_____

Community

Fam	Child	Frequency	Duration		Frequency	Duration
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Peer Mentor	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Recreation Services	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Respite	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Youth Support Groups	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Other	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____