

Student: _____

Meeting Date: _____

Section T (16):

Needed Transition Services

(To be completed for all students with a disability beginning at age 16 and reviewed annually)

Statement of Needed Transition Services: _____

Person/Agency Responsible:

- A. Student
- B. Teacher
- C. Parent/Care Provider
- D. Guidance Counselor

- E. Adult Service Provider
- F. Career Specialist
- G. Other: _____

Client of:

- YES NO Regional Center
- YES NO Dept of Rehabilitation

Activities	Describe below the activities that need to be completed during the next year that will lead to the long-range post-school goals of the student. If no activity is needed, indicate reason below.	Person/Agency Responsible (A-G)	Timeline	Date Completed
Instructional:	<input type="checkbox"/> addressed in IEP goals			
Community Experience:	<input type="checkbox"/> addressed in IEP goals			
Employment and other Post School Adult Living:	<input type="checkbox"/> addressed in IEP goals			
Related Services:	<input type="checkbox"/> addressed in IEP goals			
Needed Linkages to Outside Agencies/Providers:	<input type="checkbox"/> addressed in IEP goals			
If Appropriate: Daily Living Skills:	<input type="checkbox"/> addressed in IEP goals			
If Appropriate: Functional Career Evaluation:	<input type="checkbox"/> addressed in IEP goals			