Holmes District School Board

MTSS

Required Referral Documentation

ACADEMIC

The following worksheets/forms must be completed *before* a packet is sent to the district office. Please check each item as you complete it and arrange the documents in the order listed below. This sheet must be completed, signed, and submitted with each referral.

- ☐ MTSS 1A Required Referral Documentation
- ☐ MTSS 2 Tier 1 Core Problem Solving (this form is to be completed during grade level/subject/data meetings a minimum of 3 times per year following progress monitoring assessments)
- ☐ MTSS 3 Parent Notification of Intervention Activities
- ☐ MTSS 4 Request for Intervention Team Meeting
- ☐ MTSS 5A Student Statement of Concerns
- ☐ MTSS 6 Student History
- ☐ MTSS 7 Student Observation
- ☐ MTSS 8 Review of Exclusionary Factors
- ☐ MTSS 9 Parent Conference Screenings and Consent
- ☐ MTSS 10 Social Developmental History (Beginning of Tier 3)
- ☐ MTSS 11 Initial Functional Behavior Assessment Teacher input (if needed) and Positive Behavior Intervention Plan (if needed)
- ☐ MTSS 12 Intervention Meeting Parent Notification
- ☐ MTSS 13 Tier 2 Academic Focus Step 1
- ☐ MTSS 14 Individual Student Documentation (both Tier 2 and Tier 3)
- ☐ MTSS 15 Tier 2/Tier 3 Progress Monitoring
- ☐ MTSS 16 Tier 2 Academic Focus Step 2 (MTSS 16SEC for secondary students)
- ☐ MTSS 16A&B Tier 2 Academic Focus Step 3 and step 4 (if needed)
- ☐ MTSS 17 Tier 3 Academic Focus Step 1
  A graph of student's performance should follow (MTSS 15)
  Tier 3 Intervention Documentation should follow (MTSS 14)
- ☐ MTSS 18 Tier 3 Focus Step 2
- ☐ MTSS 18A&B Tier 3 Focus Step 3 and step 4 (if needed)

☐ ESE #2 Referral for Review of Eligibility Determination

If the SBIT has determined the need for an ESE referral, MTSS paperwork is sent to the district ESE office for review. If approved, consent will be sent home for parent/guardian signature.

Person submitting documentation: _____

Signature: _____ Date: _____

Holmes District School Board
701 East Pennsylvania Avenue
Bonifay, Fl. 32425
TEL (850) 547-9341 FAX (850) 547-0381

Tier 1- Core Focus Worksheet

School:	**Date:**
Grade:	**Teacher(s):**
Target area or subject:	

Personnel Present:

Is the core academic instruction/behavior effective for students?

Yes ☐ **No** ☐

If yes, what percent of students is the core instruction effective for?

_____%

List any demographic groups for which the core is not effective.

_____

If the core is NOT effective, what modifications will be made to the core?

_____

_____

_____

_____

List students in need of supplemental instruction.

Tier 2 Strategic Instruction

Tier 3 Intensive Instruction

For students who are in need of Tier 2 strategic instruction complete MTSS 3, MTSS 4, MTSS 12, and MTSS 13 (academic) or MTSS 13BEH (behavior) page 1 (page 2 will be completed during intervention meeting).

For students who are in need of Tier 3 intensive instruction complete MTSS 3, MTSS 4, MTSS 12, MTSS 13 (academic) or MTSS 13BEH (behavior) page 1, and MTSS 17 (academic) or MTSS 17BEH (behavior) page 1 (page 2 will be completed during intervention meeting). These students must also receive Tier 2 instruction.

***Some students may need both academic and behavior supplemental instruction.**

Parent Notification of Intervention Activities

Student _____ School Year_____ Grade_____ Teacher_____

Dear Parent/Guardian,

In an effort to maximize individual student success, our school has an Intervention Team. The mission of the Intervention Team is to:

- Identify the learning needs of students who are struggling with academics and/or behaviors and who may be at risk of school failure.
- Provide students with academic, emotional, behavioral and social support needed to succeed in school by implementing interventions within the classroom.

The Intervention Team may be comprised of teachers, administrators, school level student support staff (guidance counselor, curriculum) and additional district level staff such as the school psychologist or speech/language therapist.

To assist your child in experiencing greater school success, he/she has been referred to the school's Intervention Team to address his/her school performance. The Intervention Team would like to gather additional information by administering individual screenings/diagnostic testing/observations. The consent may include screening/testing/ observations for vision, hearing, speech, language, behavior, cognitive ability and academic functioning. Based on results of the screenings/testing/observations, behavioral and/or academic interventions may be developed and implemented.

In order to conduct the necessary screenings/testing/observations and implement intervention activities, your consent is requested. All information gathered will assist in the educational planning of your child and will be shared with you.

The following describes Tier II (supplemental) measures that will be performed daily:

Intervention being used:_____
_____
(Specify the amount of time, the focus and the program or activities used)

Please check the appropriate box below, sign your name and provide the date.

If you have any questions, please contact _____ at _____ (phone).

Please return the form to _____ at _____ (school).

Thank you for your concern and interest.

_____ YES, I give consent for my child to have individual screening/testing/observations.

_____ NO, _____.
(comments)

Parent/Guardian signature _____ Date _____

Request for Intervention Team Meeting

Student _____ School Year_____ Grade_____ Teacher_____

Date of Request _____

Parent Name _____ Phone Number _____

Parent Address _____

I request a meeting of the Intervention Team to assist in providing interventions for the above named student. I have administered Tier I Core Instruction with fidelity and determined it to be ineffective. The performance of the above named student is significantly less than benchmarks and/or approximately 80% of the class. The student's parents have been contacted concerning the effectiveness of Tier 1 Core Instruction. I have completed MTSS forms that include the Student History, Observations, Problem Solving Worksheet and Tier I Comparison.

I have observed problems that interfere with the above named student's educational progress in the following area(s): check all that apply.

☐ Academic performance with low or failing grades in:

☐ Reading ☐ Math ☐ Writing ☐ Other (specify): _____

☐ Behavior, discipline or attendance:

Specify concern: _____

☐ Language

☐ Medical

☐ Other, specify: _____

DATE RECEIVED BY THE INTERVENTION TEAM CHAIR: _____

The Intervention Team meeting has been scheduled for:

_____ at _____

(Date) (Time)

Holmes District School Board	701 East Pennsylvania Ave. Bonifay, Fl. 32425 (850) 547-9341	**STUDENT STATEMENT OF ACADEMIC CONCERNS FORM**

Student Name	School	Today's Date

DOB	Age	Current Grade	Grade Retained *(If applicable)*	Parent Phone

Parent/Guardian Name	Address

Teacher's Name	Absences	Tardies

1. Initial Parent Notification Date *(Required)*	Method of Notification: ☐ Letter to Parent/Guardian ☐ Phone ☐ Conference
2. Second Parent Notification Date	Method of Notification: ☐ Letter to Parent/Guardian ☐ Phone ☐ Conference

Concerns: ☐ Academic ☐ Communication ☐ Medical ☐ Other _____

Does the student receive ESE services? ☐ Yes ☐ No Is the student Homeless?
Does the student have a 504 Plan? ☐ Yes ☐ No ☐ Yes ☐ No

Describe *Specific* Academic Concerns:

Student Data *(Fill in all that apply with the **most current** data.)*

	FSA Level	Scale Score	iReady Scale Score	Star/FLKRS	Other Data Source *(if applicable)*
Reading					
Math					

List the Student's Current Grades Below

English / Language Arts	Math	Social Studies	Science

Prior Interventions

What specific interventions are currently implemented for this student?

Check all of the following that appear to affect the student's academic:

☐ Absences ☐ Limited English Proficiency (ELL) ☐ Motivation ☐ Hearing/Vision ☐ Concentration
☐ Medical Concerns ☐ Peer/Family Relationships ☐ Speech Articulation ☐ Social Skills ☐ Impulsivity
☐ Anxious ☐ Withdrawn ☐ Off-Task ☐ Other_____

Additional Comments *(optional)*

No person shall, on the basis of race, color, religion, gender, age, ethnicity, national origin, marital status, disability, political or religious beliefs be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity, or in any employment conditions or practices conducted by this School District, except as provided by law.

Student History

Student _____ School Year_____ Grade_____ Teacher_____

Report Card Final Grades							
	____Grade	____Grade	____Grade	____Grade	____Grade	____Grade	____Grade
Reading							
Language Arts							
Math							
Science							
Social Studies							

Grades of Previous Retentions if Applicable	

Attendance						
	____Grade	____Grade	____Grade	____Grade	____Grade	____Grade
Absences						
Tardies						

Discipline Referrals						
	____Grade	____Grade	____Grade	____Grade	____Grade	____Grade
Discipline Referrals						

District Assessment										
	____Grade		____Grade		____Grade		____Grade		____Grade	
	Reading	Math	Reading	Math	Reading	Math	Reading	Math	Reading	Math
Assessment 1										
Assessment 2										
Assessment 3										
Assessment 4										

FSA					
	____Grade	____Grade	____Grade	____Grade	____Grade
Reading					
Math					

Other:					
Date:	Date:	Date:	Date:	Date:	Date:
Score:	Score:	Score:	Score:	Score:	Score:

Other: _____

_____

Parent Signature: _____ Date: _____

Revised 2/20

Holmes District
School Board

Student Observation Worksheet

Student		**School**		**Date of Observation**	
Date of Birth		**Teacher**		**Grade**	

Observer Name & Position		**Class Activity**	
Location of Observation		**Activity Type** *(indicate one)*	Whole group ☐ Small group ☐ Independent work ☐ Other:

OBSERVATIONS: *Please "X" behaviors frequently observed. Class activity should be centered on area of concern.*

Observed Behavior		Observed Behavior	
	Reverses or confuses letters, numbers & words		Poor gross motor control
	Misinterprets verbal questions & directions		Poor fine motor control
	Makes inappropriate responses to conversation & questions		Frequently loses place when reading
	Works one/or more grade level below peers in an academic subject		Difficulty staying on line when writing
	Possible hearing problems (e.g. recurrent ear infections, tubes, allergies)		Appears inattentive, easily distracted
	Poor judgment in social & interpersonal relations		Poor understanding of vocabulary
	Constantly seeks attention, especially from adults		Speech not fluent (e.g. stuttering)
	Leads or joins other in inappropriate behavior		Low frustration tolerance
	Engages in destructive and/or aggressive behavior		Difficulty completing assignments
	Vocal quality not appropriate (e.g. hoarse, nasal, strident pitch)		Withdrawn
	Slow to react to & follow directions		Short attention span
	Performs inconsistently from day to day		Cannot imitate sounds correctly
	Difficulty following directions in sequence		Difficulty expressing ideas
	Impulsive, talks out, difficulty waiting turn		Other speech related problems, describe:

Guiding Questions for written Narrative:

1. During the observation, what was the student's response to the classroom activity? Level of participation?
2. How was the student's behavior similar to the other students in the classroom? How was the behavior different?
3. According to his/her classroom teacher, is the behavior being observed consistent with the student's daily performance? If not, how was it different?

NARRATIVE: *Please refer to the guiding questions as well as describing any observed behavior(s).*

Holmes District School Board
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Review of Exclusionary Factors

Student's Name:_____ Student Number: _____ Date of Review: _____
Date of Birth: _____ School: _____ Grade: _____ Teacher: _____

Review the following factors –THAT COULD POSSIBLY AFFECT ACCESS TO EFFECTIVE INSTRUCTION and check the appropriate box(es). Comment if information is significant.

1. Date of Entry:_____
2. Social data reviewed (ODR's, etc.) ☐ YES ☐ N/A Significant? _____
3. Attendance data reviewed ☐ YES ☐ N/A Significant?_____
4. Number of Schools attended since initial entry _____ List: _____
5. Retention: Grade(s) _____
6. Psychological Data reviewed ☐ YES ☐ N/A Significant? _____
7. Medical Data reviewed ☐ YES ☐ N/A Significant? _____
8. Achievement data reviewed ☐ YES ☐ N/A Significant? _____
   Short Cycle Assessment: Current Year results ____/____/____ Previous Year ____/____/____
9. Did the school subgroup of which the student is a member meet Adequately Yearly Progress?
   Check one: ☐ YES or ☐ NO (If the student's subgroup did not meet proficiency, provide percentage for total group and subgroup.)
10. Do cultural or language differences exist that would impact learning or affect access to effective instruction?
    Check one: ☐ YES or ☐ NO
    If YES, describe how it affects the student's performance.
    _____
    _____
11. Do economic or environmental circumstances exist that would prevent access to effective instruction?
    Check one: ☐ YES or ☐ NO If YES, list and identify how?
    _____
    _____

Factors 1 – 11 must be acceptable or addressed as part of the Tier I Decision-making process.

Are any factors unacceptable? If yes, which one(s):

_____
_____

What action is the team taking to resolve the unacceptable factor(s) or assist the student in accessing effective instruction?

_____
_____

Team Members:

_____ _____
_____ _____

Parent Conference, Screening Consent and Screening Results

Student's Name:_____
Date of Birth:_____
School:_____ **Teacher:**_____ **Grade:**_____

Parent:_____
Address:_____
Parent Contact Number:_____

A: Consent for Screenings:

I, _____, give my permission for my child, _____, to receive vision, hearing, speech screenings, as well as, any other screening(s), including academic and/or behavioral needed in making decisions within the Multi-Tiered System of Supports for my child.

Parent Signature:_____

B: Parent Conferences: (Teacher, Counselor, Parent)

Conference# _____ Date:_____

What is the student's academic or behavioral concern:

_____
_____
_____
_____
_____
_____

Conference# _____ Date:_____

What is the student's academic or behavioral concern:

_____
_____
_____
_____
_____
_____

C: SCREENINGS: (Nurse, and Speech/Language pathologist)

Screener	Status		Instrument	Date
Vision	passed	failed		
Hearing	passed	failed		
Speech	passed	failed		
Language (if required)	passed	failed		
Other _____	passed	failed		

Comments:_____
_____
_____
_____

Signature of Speech/Language pathologist:
_____

Signature of School Nurse
_____

MTSS 9

Revised 1/2020

Social/Developmental History

I. Identifying Information:

Student Name: _____ Student Number: _____

Date of Birth: _____ Current Age: _____ Grade: _____

School: _____ Race: _____ Sex: _____

Home Address: _____ Telephone: _____

Person Being Interviewed: _____

Relationship to Student: _____

Completed by: _____ Date: _____

II. Family Information:

Father's Name: _____ Age: _____ Occupation: _____

Last Grade Completed in School: _____ Is this person a legal guardian? Yes ☐ No ☐

The above person is: biological father ☐ *or* stepfather ☐ *or* other, specify: _____

Mother's Name: _____ Age: _____ Occupation: _____

Last Grade Completed in School: _____ Is this person a legal guardian? Yes ☐ No ☐

The above person is: biological mother ☐ *or* stepmother ☐ *or* other, specify: _____

Is the student adopted, in foster care or in another situation? If yes, please explain: _____

_____

_____

With whom does the student live?

_____

List other people living in the home:

Name, Age	Relationship to Child
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

III. Medical History:

Current diagnoses, disorders, illnesses, etc:

_____

Current medications:

_____

Describe pertinent medical history:

_____

_____

IV. Pregnancy/Birth:

Mother's difficulties during pregnancy:

_____

Did the mother smoke during pregnancy? _____ If yes, how much? _____

Did the mother use alcohol during the pregnancy? _____ If yes, how much? _____

Did the mother ingest prescription medications during pregnancy? _____ If yes, specify:

_____

_____

Did the mother ingest non-prescription medications during pregnancy? _____ If yes, specify:

_____

_____

The birth was: ☐ Full-term ☐ Premature, how much? _____ ☐ Overdue, how much? _____

The delivery was: ☐ Normal ☐ Caesarian-Section Birth Weight: _____

Describe any complications surrounding birth:

_____

_____

_____

V. Developmental History:

State the age at which your child did the following:
Sat alone: _____ Crawled: _____ Said first word: _____
Walked: _____ Toilet trained: _____

Note any difficulties for the above milestones:

_____
_____
_____

Did you child attend a pre-kindergarten program? ☐ Yes ☐ No If yes, where? _____
What grade(s) has your child repeated? _____

VI. Family History:

Please describe family history in the following areas.

Emotional Problems: _____

Person's relationship to student: _____

Academic Difficulties: _____

Person's relationship to student: _____

Medical/Physical Problems: _____

Person's relationship to student: _____

VII. Parent/Child Interaction:

How is the student's relationship to parents? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Describe the most effective types of discipline:

_____
_____

What circumstances commonly cause conflict between parent and student?

_____
_____

Describe how parents see the student's problem:

_____
_____

Describe when and how parents feel the student's problem began:

_____
_____

VIII. Behavioral Information:

Check and describe the student's problems in the following areas:

☐ Attention:

☐ Bedwetting/Soiling:

☐ Cruelty:

☐ Eating Concerns:

☐ Headaches/Physical Complaints:

☐ Hearing:

☐ High Activity Level :

☐ Interactions with Peers:

☐ Nail Biting:

☐ Nervousness/Anxiety:

☐ Nightmares:

☐ Physical Aggression:

☐ Prone to Accidents:

☐ Silent Periods:

☐ Sleeping:

☐ Speech:

☐ Temper Tantrums:

☐ Timidity/Shyness:

☐ Vision:

☐ Withdrawal/Depression:

☐ Worries:

☐ Other:

Intervention Meeting Parent Invitation

To the Parent/Guardian of: _____

Student _____ School Year_____ Grade_____ Teacher_____

Date: _____

The Intervention Team is a committee of people at our school that meets on a regular basis to help general education teachers find new or different ways to help specific students to achieve academic or behavioral success at school. Your child has been referred to the team by his/her classroom teacher.

Meetings are held on a regular basis regarding students referred to the Intervention Team to discuss appropriate interventions to help your child succeed academically and/or behaviorally in the general education setting. Meetings are also held to discuss your child's response to the interventions and make further recommendations.

You are invited to attend and participate in these important meetings pertaining to your child. You will have the opportunity to express any concerns you have or ask questions you may have regarding your child.

The meeting is scheduled for:

Date: _____

Time: _____

Location: _____

If you have questions or need more information, please do not hesitate to contact _____

at _____.
(phone)

PLEASE CHECK THE APPROPRIATE RESPONSE, SIGN AND RETURN TO THE SCHOOL PRIOR TO THE SCHEDULED MEETING.

_____ Yes, I will attend the meeting.

_____ I do not plan to attend the meeting. You may contact me at _____ (phone) to discuss the results of the meeting.

_____ _____
Parent/Guardian Signature Date

Holmes District School Board	701 East Pennsylvania Ave. Bonifay, FL 32425 (850) 547-9341	MULTI-TIERED SYSTEM OF SUPPORTS TIER 2 ACADEMIC FOCUS WORKSHEET – Secondary

Student Name	Grade	Date of Initial Meeting
School	Teacher	

Reason for the Problem

State the reason/hypothesis the student is performing below grade level:

Reason for the Problem: Check all that Apply and Provide Details for Each

☐ **Instruction** *(i.e. types of student production, methods of teaching practices, etc.)*:

☐ **Curriculum** *(i.e. rigor, scope & sequence expectations, level of assignments & curriculum material difficulties, etc.)*:

☐ **Environment** *(i.e. rules & policies, routines & management, adult & peer interactions, etc.)*:

☐ **Other** *(i.e. medical, onset & duration, etc.)*:

Target Areas *(check all that apply)*

☐ **Reading**	☐ Phonemic Awareness/Phonics	☐ Fluency	☐ Vocabulary	☐ Comprehension
☐ **Math**	☐ Numbers/Operations	☐Geometry/Measurement	☐ Algebra	☐ Problem Solving
☐ **Language**	☐ Receptive Language	☐Expressive Language	☐ Pragmatic Language	

☐ **Other** _____ **Core is effective for _____ % of all students.**

Intervention Documentation must be provided for all "Target Areas" checked.

In _____ weeks, the student(s) will:

Student Name:

Tier 2 – Intervention Plan

Date of Initial Meeting	Beginning Date of Plan

1. What is the name of the research-based Intervention/Curriculum?

   _____

   How often will the student receive the intervention? _____ minutes daily

2. What is the name of the research-based Intervention/Curriculum?

   _____

   How often will the student receive the intervention? ☐ Daily ☐ Weekly ☐ Other _____

List and describe any accommodations the student is receiving or will receive as a result of their academic achievement and / or this plan.

Personnel Responsible for the Intervention

Personnel Name and Position	Name of Research-Based Intervention Program	Responsibilities/Duties Performed for Plan Implementation *(i.e. deliver program, ensure fidelity)*

Signatures of MTSS Team Members at Initial Meeting

Teacher	School Administrator
Teacher	Administrator or Designee
Parent/Guardian	Guidance Counselor
Parent/Guardian	Curriculum Coordinator
School or District Personnel	School or District Personnel

Date for Plan follow-up and review
(It is recommended that this date be scheduled during the initial planning meeting)

Notes or Comments:

Intervention Documentation Worksheet

SMALL GROUP INSTRUCTION Teacher: _____

Week of: _____

Tier II Student List	Monday			Tuesday			Wednesday			Thursday			Friday			Total # of Minutes	Progress Monitoring Results
	T	P	F	T	P	F	T	P	F	T	P	F	T	P	F		

T = Time (# of minutes) P = Program F = Focus	**Focus** L = Language PA = Phonemic Awareness P = Phonics F = Fluency V = Vocabulary C = Comprehension	**Program** *(Create your own key. For example. W = Wilson Fundations)* R = Reading First ____ = _____ ____ = _____

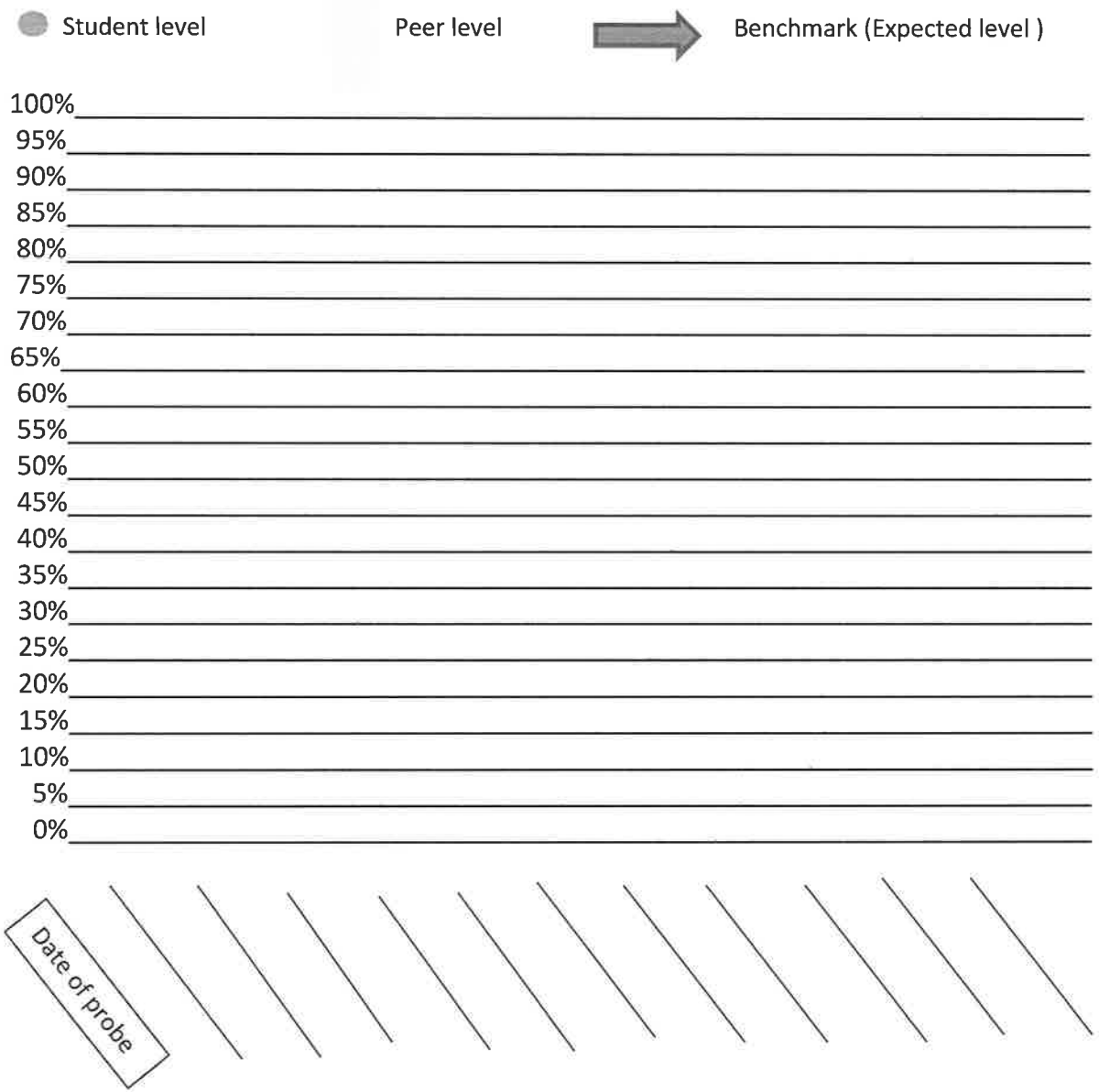
MTSS 2a

Tier II Progress Monitoring

Student name_____ **Grade**_____

Teacher_____ **School**_____

Date initiated_____



I certify that the information on the progress Monitoring Worksheet is true and correct.
Signature of Teacher_____

By my signature, I have received a copy of this document.
Signature of Parent_____

Date:_____

MTSS 15

Revised 9/19

Follow-Up and Review Meeting for the Tier 2 Plan	
Student Name	**Plan Follow-Up and Review Meeting Date**

Progress Monitoring for the Tier 2 Plan	
Assessment Tool *(use program assessment piece if available)*	**Target Skill**
Personnel Who Collected Progress Monitoring Data *(Name and Position)*	**Date(s) Progress Monitoring Occurred**

Was the goal achieved? ☐ **Yes** ☐ **No**

Describe the specific results/outcomes (data) of the Plan:

Review of Response to Intervention for the Tier 2 Plan	
☐ **Positive** *(the gap is closing)*	☐ Continue intervention(s) with current goal and monitor regularly. ☐ Continue intervention(s) with goal increased and monitor regularly. ☐ Fade intervention(s) to determine if student has acquired functional independence (monitor regularly).
☐ **Questionable** *(the gap remains the same)*	**Was/were the intervention(s) implemented as intended?** ☐ **Yes** ☐ **No** If ***no***, employ strategies to increase implementation integrity. Once interventions are properly implemented, reassess response. If ***yes***, continue intensity of current intervention(s) for a short period of time then reassess impact. If student improves, continue; if student does not improve, implement Tier 3.
☐ **Poor** *(the gap has increased)*	**Was/were the intervention(s) implemented as intended?** ☐ **Yes** ☐ **No** If ***no***, identify strategies to increase integrity of intervention implementation. After interventions are properly implemented, reassess response. If ***yes***, was the problem identified correctly? ☐ **Yes** ☐ **No** If ***yes***, increase intervention intensity and add Tier 3 interventions If ***no***, return to problem solving and implement a new plan and add Tier 3 interventions

Next Actions / To Do:

Notes or Comments:

Date for next follow-up and review
(It is recommended that this date be scheduled during the current meeting)

Signatures of MTSS Team Members at the Tier 2 Plan Follow-up Meeting	
Teacher	**School Administrator**
Teacher	**Administrator or Designee**
Parent/Guardian	**Guidance Counselor**
Parent/Guardian	**Curriculum Coordinator**
School or District Personnel	**School or District Personnel**

Follow-Up and Review Meeting for Plan #2	
Student Name	**Plan #2 Follow-Up and Review Meeting Date**
Progress Monitoring for Plan #2	
Assessment Tool *(use program assessment piece if available)*	**Target Skill**
Personnel Who Collected Progress Monitoring Data *(Name and Position)*	**Date(s) Progress Monitoring Occurred**
Was the goal achieved? ☐ **Yes** ☐ **No** **Describe the specific results/outcomes (data) of Plan #2:**	
Review of Response to Intervention for Plan #2	
☐ **Positive** *(the gap is closing)*	☐ Continue intervention(s) with current goal and monitor regularly. ☐ Continue intervention(s) with goal increased and monitor regularly. ☐ Fade intervention(s) to determine if student(s) has/have acquired functional independence (monitor regularly).
☐ **Questionable** *(the gap remains the same)*	**Was/were the intervention(s) implemented as intended?** ☐ **Yes** ☐ **No** If ***no***, employ strategies to increase implementation integrity. Once interventions are properly implemented, reassess response. If ***yes***, continue intensity of current intervention(s) for a short period of time then reassess impact. If student(s) improves, continue; if student(s) does not improve, add Tier 3 interventions.
☐ **Poor** *(the gap has increased)*	**Was/were the intervention(s) implemented as intended?** ☐ **Yes** ☐ **No** If ***no***, identify strategies to increase integrity of intervention implementation. After interventions are properly implemented, reassess response. If ***yes***, was the problem identified correctly? ☐ **Yes** ☐ **No** If ***yes***, increase intervention intensity ***and*** add Tier 3 interventions If ***no***, return to problem solving, implement ***appropriate*** Tier 2 ***and*** Tier 3 interventions
Next Actions / To Do:	
Notes or Comments:	
Date for next follow-up and review *(it is recommended that this date be scheduled during the current meeting)*	
Signatures of MTSS Team Members at Plan #2 Follow-up Meeting	
Teacher	**School Administrator**
Teacher	**Administrator or Designee**
Parent/Guardian	**Guidance Counselor**
Parent/Guardian	**Curriculum Coordinator**
School or District Personnel	**School or District Personnel**

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Student Name:	
Tier 2 – Intervention Plan #2	
Date of Plan #2 Meeting	Beginning Date of Plan #2
1. What is the name of the research-based Intervention/Program? _____ How often will the student(s) receive the intervention? ____ minutes daily	
2. What is the name of the research-based Intervention/Program? _____ How often will the student(s) receive the intervention? ☐ Daily ☐ Weekly ☐ Other _____	
3. What is the name of the research-based Intervention/Program? _____ How often will the student(s) receive the intervention? ____ times per ____	
List and describe any accommodations the student is receiving or will receive as a result of their academic achievement and / or this plan.	

Personnel Responsible for Plan #2 Intervention		
Personnel Name and Position	Name of Research-Based Intervention Program	Responsibilities/Duties Performed for Plan Implementation *(i.e. deliver program, ensure fidelity)*

Signatures of MTSS Team Members at Plan #2 Initial Meeting	
Teacher	School Administrator
Teacher	Administrator or Designee
Parent/Guardian	Guidance Counselor
Parent/Guardian	Curriculum Coordinator
School or District Personnel	School or District Personnel
Date for Plan #2 follow-up and review *(It is recommended that this date be scheduled during the meeting)*	
Notes or Comments:	

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Holmes District School Board	701 East Pennsylvania Ave. Bonifay, FL 32425 (850) 547-9341	MULTI-TIERED SYSTEM OF SUPPORTS TIER 3 ACADEMIC INTENSIVE INTERVENTION FOCUS WORKSHEET		
Student Name	**Student Grade**	**Student DOB**	**Student Age**	**Date of Initial Meeting**
School		**Teacher**		
Student Gender ☐ M ☐ F	**Total Number of Absences**	**Total Number of Tardies**		

Academic Data

Data Source 1 (*i.e., iReady, Achieve, Running Record*)			**Date Data Collected**
Student Level of Performance	**Peer Level of Performance**	**Gap Between Student and Peer**	**Student Expected Level of Performance**
Data Source 2 (*Must come from a different data source than Source 1*)			**Date Data Collected**
Student Level of Performance	**Peer Level of Performance**	**Gap Between Student and Peer**	**Student Expected Level of Performance**

What is the Tier 2 Target Area & Research-Based Intervention?

Reason for the Problem

State the reason/hypothesis for the student's performance gap recorded above:

Reason for the Problem: Check all that Apply and Provide Details for Each

☐ **Instruction** *(i.e. types of student production, methods of teaching practices, etc.)*:

☐ **Curriculum** *(i.e. rigor, scope & sequence expectations, level of assignments & curriculum material difficulties, etc.)*:

☐ **Environment** *(i.e. rules & policies, routines & management, adult & peer interactions, etc.)*:

☐ **Other** *(i.e. medical, onset & duration, etc.)*:

Target Areas *(check all that apply)*

☐ **Reading**	☐ Phonemic Awareness/Phonics	☐ Fluency	☐ Vocabulary	☐ Comprehension
☐ **Math**	☐ Numbers/Operations	☐Geometry/Measurement	☐ Algebra	☐ Problem Solving
☐ **Language**	☐ Receptive Language	☐Expressive Language	☐ Pragmatic Language	

Intervention Documentation must be provided for all "Target Areas" checked.

In _____ weeks, the student will:

No person shall, on the basis of race, color, religion, gender, age, ethnicity, national origin, marital status, disability, political or religious beliefs, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity, or any employment conditions or practices conducted by this School District, except as provided by law.

Student Name:	
Tier 3 – Intervention Plan #1	
Date of Initial Meeting	Beginning Date of Plan #1
1. What is the name of the research-based Intervention/Program? _____ How often will the student(s) receive the intervention? ____ minutes daily	
2. What is the name of the research-based Intervention/Program? _____ How often will the student(s) receive the intervention? ☐ Daily ☐ Weekly ☐ Other _____	
3. What is the name of the research-based Intervention/Program? _____ How often will the student(s) receive the intervention? ____ times per ____	
List and describe accommodations (if any) the student has or will receive as a result of their academic achievement and / or this plan.	

Personnel Responsible for Plan #1 Intervention		
Personnel Name and Position	Name of Research-Based Intervention Program	Responsibilities/Duties Performed for Plan Implementation *(i.e. deliver program, ensure fidelity)*

Signatures of MTSS Team Members at Plan #1 Initial Meeting	
Teacher	School Administrator
Teacher	Administrator or Designee
Parent/Guardian	Guidance Counselor
Parent/Guardian	Curriculum Coordinator
School or District Personnel	School or District Personnel
Date for Plan #1 follow-up and review *(it is recommended that this date be scheduled during the planning meeting)*	
Notes or Comments:	

No person shall, on the basis of race, color, religion, gender, age, ethnicity, national origin, marital status, disability, political or religious beliefs, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity, or any employment conditions or practices conducted by this School District, except as provided by law.

Follow-Up and Review Meeting for Plan #1	
Student Name	**Follow-Up and Review Meeting Date**
Progress Monitoring for Plan #1	
Assessment Tool *(use program assessment piece if available)*	**Target Skill**
Personnel Who Collected Progress Monitoring Data *(Name and Position)*	**Date(s) Progress Monitoring Occurred**

Was the goal achieved? ☐ **Yes** ☐ **No**
Describe the specific results/outcomes (data) of Plan #1:

Review of Response to Intervention for Plan #1	
☐ **Positive** *(the gap is closing)*	☐ Continue intervention(s) with current goal and monitor regularly. ☐ Continue intervention(s) with goal increased and monitor regularly. ☐ Fade intervention(s) to determine if student has acquired functional independence (monitor regularly).
☐ **Questionable** *(the gap remains the same)*	**Was/were the intervention(s) implemented as intended?** ☐ **Yes** ☐ **No** If ***no***, employ strategies to increase implementation integrity. Once interventions are properly implemented, reassess response. If ***yes***, continue intensity of current intervention(s) for a short period of time then reassess impact. If student improves, continue; if student does not improve, implement Plan #2.
☐ **Poor** *(the gap has increased)*	**Was/were the intervention(s) implemented as intended?** ☐ **Yes** ☐ **No** If ***no***, identify strategies to increase integrity of intervention implementation. After interventions are properly implemented, reassess response. If ***yes***, was the problem identified correctly? ☐ **Yes** ☐ **No** If ***yes***, increase intervention intensity If ***no***, return to problem solving and implement a new plan (Plan #2 MTSS 18A) If, due to the severity of the situation, Plan #2 is not warranted, submit a completed copy of the file to your District MTSS department for review.

Next Actions / To Do:

Notes or Comments:

Date for next follow-up and review
(it is recommended that this date be scheduled during the current meeting)

Signatures of MTSS Team Members at Plan #1 Follow-Up Meeting	
Teacher	**School Administrator**
Teacher	**Administrator or Designee**
Parent/Guardian	**Guidance Counselor**
Parent/Guardian	**Curriculum Coordinator**
School or District Personnel	**School or District Personnel**

Individual Student Intervention Documentation Worksheet

Student Name: _____ **Teacher:** _____

Week of: _____	Monday			Tuesday			Wednesday			Thursday			Friday			Total # of Minutes	Progress Monitoring Results
	T	P	F	T	P	F	T	P	F	T	P	F	T	P	F		

T = Time (# of minutes) P = Program F = Focus	**Focus** L = Language PA = Phonemic Awareness P = Phonics F = Fluency V = Vocabulary C = Comprehension	**Program** *(Create your own key. For example. W = Wilson Fundations)* __R__ = Reading First ____ = _____ ____ = _____

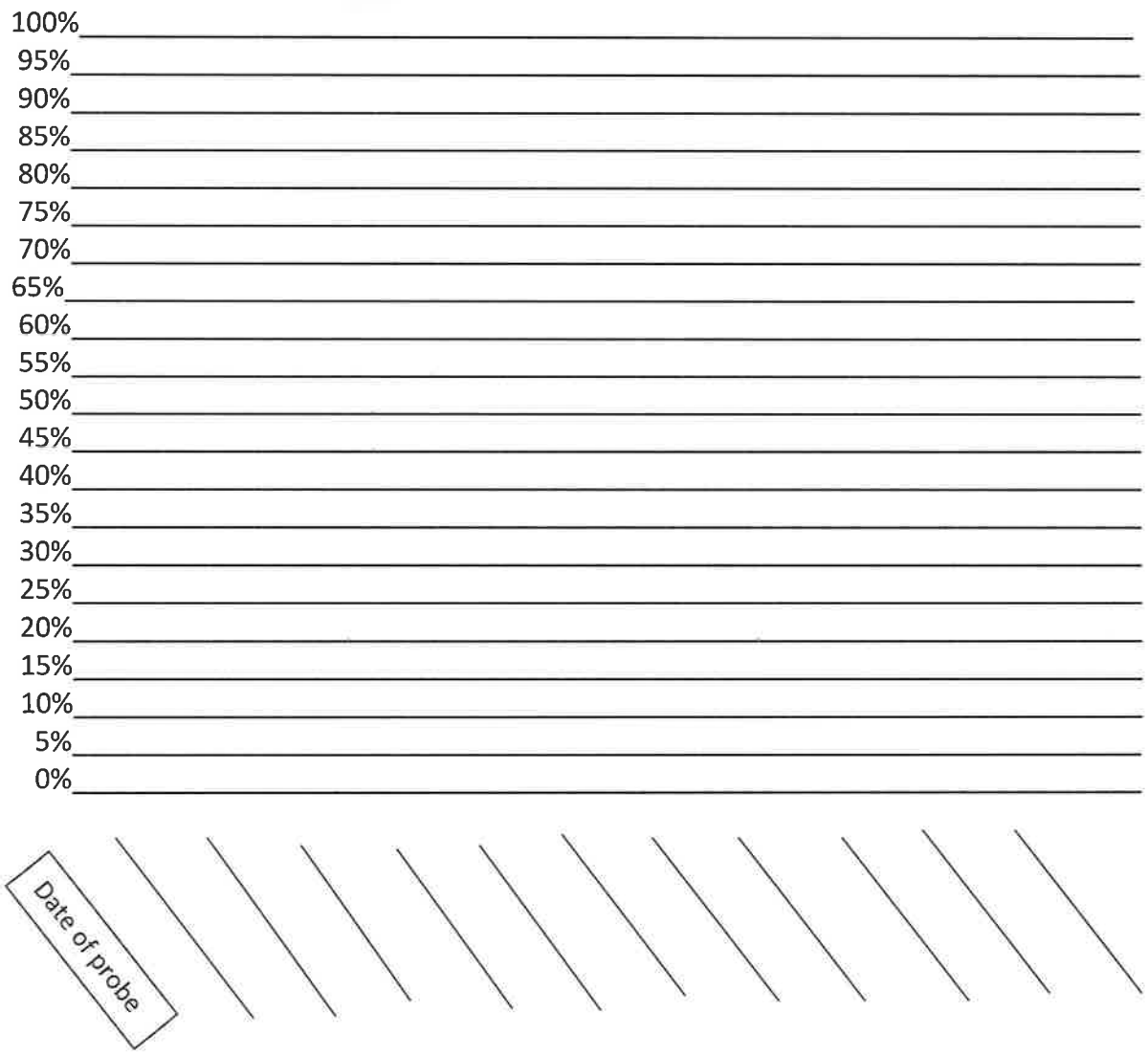
Tier III Progress Monitoring

Student name_____ **Grade**_____

Teacher_____ **School**_____

Date initiated_____

Student level Peer level Benchmark (Expected level)



I certify that the information on the progress Monitoring Worksheet is true and correct.
Signature of Teacher_____

By my signature, I have received a copy of this document.
Signature of Parent_____

Date:_____

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Student Name:	
Tier 3 – Intervention Plan #2	
Date of Initial Meeting	**Beginning Date of Plan #2**
1. What is the name of the research-based Intervention/Program? _____ **How often will the student(s) receive the intervention? ____ minutes daily**	
2. What is the name of the research-based Intervention/Program? _____ **How often will the student(s) receive the intervention? ☐ Daily ☐ Weekly ☐ Other _____**	
3. What is the name of the research-based Intervention/Program? _____ **How often will the student(s) receive the intervention? ____ times per ____**	
List and describe accommodations (if any) the student has or will receive as a result of their academic achievement and / or this plan.	

Personnel Responsible for Plan #2 Intervention		
Personnel Name and Position	**Name of Research-Based Intervention Program**	**Responsibilities/Duties Performed for Plan Implementation** *(i.e. deliver program, ensure fidelity)*

Signatures of MTSS Team Members at Plan #2 Initial Meeting	
Teacher	**School Administrator**
Teacher	**Administrator or Designee**
Parent/Guardian	**Guidance Counselor**
Parent/Guardian	**Curriculum Coordinator**
School or District Personnel	**School or District Personnel**
Date for Plan #2 follow-up and review ***(It is recommended that this date be scheduled during the meeting)***	
Notes or Comments:	

No person shall, on the basis of race, color, religion, gender, age, ethnicity, national origin, marital status, disability, political or religious beliefs, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity, or any employment conditions or practices conducted by this School District, except as provided by law.

Follow-Up and Review Meeting for Plan #2	
Student Name	**Follow-Up and Review Meeting Date**
Progress Monitoring for Plan #2	
Assessment Tool *(use program assessment piece if available)*	**Target Skill**
Personnel Who Collected Progress Monitoring Data *(Name and Position)*	**Date(s) Progress Monitoring Occurred**

Was the goal achieved? ☐ **Yes** ☐ **No**
Describe the specific results/outcomes (data) of Plan #2:

Review of Response to Intervention for Plan #2	
☐ **Positive** *(the gap is closing)*	☐ Continue intervention(s) with current goal and monitor regularly. ☐ Continue intervention(s) with goal increased and monitor regularly. ☐ Fade intervention(s) to determine if student has acquired functional independence (monitor regularly).
☐ **Questionable** *(the gap remains the same)*	**Was/were the intervention(s) implemented as intended?** ☐ **Yes** ☐ **No** If ***no***, employ strategies to increase implementation integrity. Once interventions are properly implemented, reassess response. If ***yes***, continue intensity of current intervention(s) for a short period of time then reassess impact. If student improves, continue; if student does not improve, implement Plan #2.
☐ **Poor** *(the gap has increased)*	**Was/were the intervention(s) implemented as intended?** ☐ **Yes** ☐ **No** If ***no***, identify strategies to increase integrity of intervention implementation. After interventions are properly implemented, reassess response. If ***yes***, was the problem identified correctly? ☐ **Yes** ☐ **No** If ***yes***, submit a completed copy of the MTSS file to your District MTSS department for review If ***no***, return to problem solving (include the consideration of submitting a copy of the MTSS file for review)

Next Actions / To Do:

Notes or Comments:

Date for next follow-up and review
(It is recommended that this date be scheduled during the current meeting)

Signatures of MTSS Team Members at Plan #2 Follow-Up Meeting	
Teacher	**School Administrator**
Teacher	**Administrator or Designee**
Parent/Guardian	**Guidance Counselor**
Parent/Guardian	**Curriculum Coordinator**
School or District Personnel	**School or District Personnel**