


*Special Education Expenditure Project (SEEP)
Sponsored by the U.S. Department of Education*

| <i>Contact information</i> | |
|--|-------|
| <i>Please complete the required information before returning this questionnaire</i> | |
| School (required) | _____ |
| District (required) | _____ |
| State (required) | _____ |
| Respondent Name (optional) | _____ |
| Phone (optional) | _____ |
| Email (optional) | _____ |

School Questionnaire, Part II-C

*Special Education Programs Operated by Intermediate Educational Units**

*e.g., Boards of Cooperative Education Services, County Offices, Intermediate Units, Administrative Educational Areas

 **Once completed, please return this questionnaire to the designated study coordinator at your school.**

Under this option, the special education students served by this program are generally not counted as part of your enrollment. (If the students are counted as part of your school enrollment, then the special education program for purposes of this data collection should be reported in Part II-A and no information should be reported in Part II-C.)

Identification of the IEU: What is the name of the intermediate education unit (IEU) that operates this program?

Name of IEU: _____

Thank you for your participation!

INFORMATION ABOUT REPORTING BURDEN

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1820-0629. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Education, Washington, D.C. 20202-2731. If you have comments or concerns regarding your individual submission of this form, write directly to: Scott Brown, Office of Special Education Programs, U.S. Department of Education, 400 Maryland Ave., SW, Washington, D.C. 20202.

OMB Number 1820-0629

Expiration Date: 02/28/2003



AMERICAN INSTITUTES FOR RESEARCH

1. **Special education programs operated by intermediate educational unit.** Are there any special education programs housed on your school campus that are operated by an intermediate educational unit such as a county office of education, board of cooperative educational services, or intermediate unit of any kind? *Generally, such programs are administered by someone other than the principal of your school, and are operated as part of the special education program of an independent local education agency.*

Yes → **GO TO ITEM 2**
 No → **STOP.** You do not need to complete this questionnaire. Please return it to your site coordinator.

TOTAL SPECIAL EDUCATION ENROLLMENT by Age Level and Disability

2. How many special education students are currently enrolled in your school? Please report the IDEA-Part B (Individuals with Disabilities Education Act) enrollment as of the most current date for which such information is available. Please provide **your best estimate** of the composition of your students by disability even if your district does not commonly classify students this way. If you are unable to report the breakdown by disability for preschool age special education students, please report the total enrollment totals at the bottom of the table.

| IDEA Classification | Number of students you serve at this school <i>(Count each student in only one category)</i> |
|--|---|
| PRESCHOOL-AGES 3 THROUGH 5 | |
| Autism | _____ or none <input type="checkbox"/> |
| Deaf-blindness | _____ or none <input type="checkbox"/> |
| Developmental delay | _____ or none <input type="checkbox"/> |
| Emotional disturbance | _____ or none <input type="checkbox"/> |
| Hearing impairment or deafness | _____ or none <input type="checkbox"/> |
| Mental retardation | _____ or none <input type="checkbox"/> |
| Multiple disabilities | _____ or none <input type="checkbox"/> |
| Orthopedic impairment | _____ or none <input type="checkbox"/> |
| Other health impairment | _____ or none <input type="checkbox"/> |
| Specific learning disability | _____ or none <input type="checkbox"/> |
| Speech or language impairment | _____ or none <input type="checkbox"/> |
| Traumatic brain injury | _____ or none <input type="checkbox"/> |
| Visual impairment or blindness | _____ or none <input type="checkbox"/> |
| Total preschool-age special education | _____ or none <input type="checkbox"/> |
| AGES 6 THROUGH 22 | |
| Autism | _____ or none <input type="checkbox"/> |
| Deaf-blindness | _____ or none <input type="checkbox"/> |
| Developmental delay | _____ or none <input type="checkbox"/> |
| Emotional disturbance | _____ or none <input type="checkbox"/> |
| Hearing impairment or deafness | _____ or none <input type="checkbox"/> |
| Mental retardation | _____ or none <input type="checkbox"/> |
| Multiple disabilities | _____ or none <input type="checkbox"/> |
| Orthopedic impairment | _____ or none <input type="checkbox"/> |
| Other health impairment | _____ or none <input type="checkbox"/> |
| Specific learning disability | _____ or none <input type="checkbox"/> |
| Speech or language impairment | _____ or none <input type="checkbox"/> |
| Traumatic brain injury | _____ or none <input type="checkbox"/> |
| Visual impairment or blindness | _____ or none <input type="checkbox"/> |
| Total school-age special education | _____ or none <input type="checkbox"/> |

PRESCHOOL ENROLLMENT in Special Education Settings and Services.

3. Do you have any preschool special education students at your school in programs operated by an intermediate educational unit who are not counted as part of your school enrollment?

- Yes → GO TO ITEM A
 No → SKIP TO ITEM 4

A. How many of the preschool-aged special education students are currently being served in each of the following instructional settings or services? A student should be counted under **each** of the instructional settings or services he/she receives.

| INSTRUCTIONAL SETTING OR SERVICE | Number of preschool special education students served in each setting | |
|--|---|----------------------------------|
| a. Self-contained special classroom. Students receive instructional services from a special education teacher in a self-contained class designed primarily for special education students. Students <i>commonly</i> spend 60 percent or more of their time in this type of class. | _____ | or none <input type="checkbox"/> |
| b. Resource specialist – pull-out program. Students receive instructional services from a special education resource specialist/teacher in a pull-out setting. This pull-out model is most commonly found in an <i>elementary school</i> . | _____ | or none <input type="checkbox"/> |
| c. Resource specialist – in-class program. Students receive services from a special education resource specialist/teacher who comes into the general education classroom setting with the general education classroom teacher. | _____ | or none <input type="checkbox"/> |
| d. Speech/language therapy | _____ | or none <input type="checkbox"/> |
| e. Physical therapy | _____ | or none <input type="checkbox"/> |
| f. Occupational therapy | _____ | or none <input type="checkbox"/> |
| g. Audiological services | _____ | or none <input type="checkbox"/> |
| h. Vision services | _____ | or none <input type="checkbox"/> |
| i. Counseling | _____ | or none <input type="checkbox"/> |
| j. Other Services | _____ | or none <input type="checkbox"/> |
| k. Full-time instructional health or nursing aide. Full-time means 60 percent or more of the school day. | _____ | or none <input type="checkbox"/> |
| l. Part-time instructional health or nursing aide. Part-time means less than 60 percent of the school day. | _____ | or none <input type="checkbox"/> |
| m. Extended time instructional services. | | |
| Before-school instruction | _____ | or none <input type="checkbox"/> |
| After-school instruction | _____ | or none <input type="checkbox"/> |
| Weekend program instruction | _____ | or none <input type="checkbox"/> |

SCHOOL-AGED (K-12) ENROLLMENT in Special Education Settings and Services

4. How many school-aged special education students are currently being served in each of the following instructional settings or services in programs operated by an intermediate educational unit **who are not counted as part of your school enrollment?** A student should be counted under **each** of the instructional settings or services he/she receives.

| INSTRUCTIONAL SETTING OR SERVICE | Number of school-aged special education students served in each setting |
|--|---|
| a. Self-contained special classroom. Students receive instructional services from a special education teacher in a self-contained class designed primarily for special education students. Students <i>commonly</i> spend 60 percent or more of their time in this type of class. | _____ or none <input type="checkbox"/> |
| b. Resource specialist – pull-out program. Students receive instructional services from a special education resource specialist/teacher in a pull-out setting. This pull-out model is most commonly found in an <i>elementary</i> school. | _____ or none <input type="checkbox"/> |
| c. Resource specialist – in-class program. Students receive services from a special education resource specialist/teacher who comes into the general education classroom setting with the general education classroom teacher. | _____ or none <input type="checkbox"/> |
| d. Departmentalized special education class. Students receive services from a special education resource teacher in a separate subject area class designed specifically for special education students. (These classes are most commonly found in <i>secondary schools</i> .) | _____ or none <input type="checkbox"/> |
| e. Speech/language therapy | _____ or none <input type="checkbox"/> |
| f. Physical therapy | _____ or none <input type="checkbox"/> |
| g. Occupational therapy | _____ or none <input type="checkbox"/> |
| h. Audiological services | _____ or none <input type="checkbox"/> |
| i. Vision services | _____ or none <input type="checkbox"/> |
| j. Counseling | _____ or none <input type="checkbox"/> |
| k. Other Services | _____ or none <input type="checkbox"/> |
| l. In-class special education aide. Students receive services from a special education instructional aide in the general education classroom setting. | _____ or none <input type="checkbox"/> |
| m. Full-time instructional health or nursing aide. Full-time means 60 percent or more of the school day. | _____ or none <input type="checkbox"/> |
| n. Part-time instructional health or nursing aide. Part-time means less than 60 percent of the school day. | _____ or none <input type="checkbox"/> |
| o. Extended time instructional services. | |
| Before-school instruction | _____ or none <input type="checkbox"/> |
| After-school instruction | _____ or none <input type="checkbox"/> |
| Weekend program instruction | _____ or none <input type="checkbox"/> |

Once completed, please return this questionnaire to the study coordinator at this site.

Thank you for your participation!

IDENTIFICATION

All responses provided for this study are kept confidential; however, sometimes we need to follow up to clarify a response. To help us make this contact, we request that you please fill in the information below. We probably will not need the information but would appreciate having it, just in case. Once the survey data are all entered, we will delete all identifying information from our files.

Respondent Name: _____

Phone: (_____) _____ - _____ ext. _____

Best Day and Times to Reach You

Days: M T W Th F *between* _____ : _____ **AM** or **PM** (*circle*) and _____ : _____ **AM** or **PM** (*circle*)