SANTA CLARA COUNTY

OFFER OF FAPE
SUPPLEMENTARY AIDS AND SERVICES

Name ____ IEP Date _____/_____/_____

SUPPLEMENTARY AIDS AND SERVICES TO BE PROVIDED TO THE CHILD OR ON BEHALF OF THE CHILD And PROGRAM MODIFICATIONS OR SUPPORTS FOR SCHOOL PERSONNEL

Aids, Services, Program Accommodations/Modifications, and/or Supports	To Support:	Start/End Date	Frequency	Duration	Location
	☐Student ☐Personnel	/ / / /			
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Programs and services will be provided according to where student is in attendance and consistent with the district of service calendar and scheduled services, excluding holidays, vacations, and non-instructional days unless otherwise specified.