Intermediate School District 917
Referral for Special Education Services

STUDENT INFORMATION

Student's Name: _____
Last First Middle
State Reporting I.D. #: _____
(13 Digit MARSS Number **Required)**

Sex:____ Home Primary Language:_____ DOB:_____ Current Grade:____ Race:
(check all that apply) __ Hispanic __ American Indian __ Asian __ Black __ White __ Pacific Islander

Parent/Legal Guardian name: _____Relationship:_____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: ____-_____ Work Phone: ____-_____ Cell Phone: ____-_____

Other Parent/Foster Parent/Group Home/Student's Residence (circle one):_____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: ____-_____ Work Phone: ____-_____ Cell Phone: ____-_____

Contact Person:_____ (circle one) Conservator, Guardian ad Litem, Social Worker, Probation Officer
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: ____-_____ Work Phone: ____-_____ Cell Phone: ____-_____
Is this student a Ward of the State? _____

School student is currently attending: _____ District student attends: _____
District in which parent resides: _____ District in which student resides: _____

We are requesting District 917 representation on our child study team in order to review District 917 service options during school year ____ -____ for the following program(s):

CENTER BASED PROGRAMS

__ Dakota Alternative for Severely Disabled (DASH)
__ Deaf/Hard of Hearing Resource (D/HOH)*
__ Riverside School/New Chance (Corrections)
__ Intra Dakota Educational Alternative (IDEA Alliance)
__ Intra Dakota Educational Alternative (IDEA Satellites)
__ Transition Education Service Alternative (TESA)
__ Students with Unique Needs (SUN Alliance)
__ Students with Unique Needs (SUN Cedar)
__ Therapeutic Education Alternative (TEA)
__ Program Alternative for Communication, Education & Socialization (PACES)
__ DCALS Special Education

PURCHASE OF SERVICE

__ Audiology*
__ Deaf/Hard of Hearing*
__ Physically Impaired*
__ Physical Therapy*
__ Visually Impaired*
__ Sign Language Interpreter/
Cued Language Transliterator/
Transcriber (circle one)

***Medical information necessary for referral for these services.**

STUDENT'S SPECIAL EDUCATION INFORMATION Student: _____

Does this student have an IEP? YES NO Date of current IEP: _____/_____/_____

This is a request for an initial evaluation for services: YES NO Student's primary disability:_____

Date of last formal education evaluation: ____/____/___ Secondary disability, if any: _____

List student's related services: _____

Name of Local District Case Manager: _____ Phone: (_____)_____

Name of Local District Contact Person: _____ Phone: (_____)_____

STUDENT TESTING INFORMATION FOR STUDENTS IN GRADES 8-12 ONLY

Basic Standards Test Results: Scaled Scores/Test date

Reading: _____/_____-_____-_____ Math: _____/_____-_____-_____ Writing: _____/_____-_____-_____

Is student exempt? YES NO Pass Individual Score: _____

GRAD Score results: Writing: _____ Math:_____ Reading: _____

917 REFERRAL CHECKLIST

____ This form is completed in its entirety and signed by local district special education director.

____ Attached is the student's current IEP. **(required)**

____ Attached is the last three-year evaluation team summary report. **(required)**

____ Attached is the student's most current psychological evaluation.

____ Attached are other pertinent evaluations and reports (i.e. FBA and transition).

____ **(Center Based Program Referral Only)** A written summary of the last child study team meeting including:

1) names of persons in attendance 2) summary of service options considered 3) documentation as to why the local team is recommending the 917 resource program 4) the date of the last meeting in which the 917 placement was discussed with the parent was _____/_____/_____.

____ Medical documentation is required for the following program referrals and is attached:

- ❑ Deaf and Hard of Hearing – audiological documentation by a certified audiologist
- ❑ Physically Impaired – documentation of a medically diagnosed physical impairment
- ❑ Physical Therapy – doctor's prescription
- ❑ Vision - documentation of a medically diagnosed visual impairment by a doctor or ophthalmologist

The following information must be provided at the Intake meeting:

1. Student's immunization records
2. Student's Medical Assistance Number, if consent will be given for MA IEP Billing
3. Student's Metro Mobility Card Number, if applicable

This form is complete and the required information necessary for planning for the student's education program is attached.

_____ _____ _____/_____/_____

Signature of Referring Special Ed Director District Number Referral Date

Please fax referral and documentation directly to Melissa Schaller, Director of Special Education, at 651-423-8776 **OR** mail to 917 Special Education Office, 1300 145th St. E., Rosemount, MN 55068-2999

District 917 Use Only Date received by 917: _____ By: _____ revised 4/22/13

Supervisor Assigned: _____ Intake Staff Assignment:_____ Date assigned: _____