FCOE Special Education
Moderate/Severe Disabilities
Program Application

Moderate/Severe Disabilities

FCOE provides educational services for students ***ages 3-22*** through regional programs including Beth Ramacher Educational Complex in Fresno, the Monte Vista Program in Reedley and Sutherland in Kerman. All three of these programs operated by FCOE include a main school site as well as satellite classes located on various general education school campuses. As students reach adulthood the ***FCOE Adult Transition Program is available***. Major emphasis of the program for students with moderate/ severe disabilities is to teach students in the areas of pre-academics, functional academics, vocational, self-help, social and recreation/leisure. Our services include a community-based program designed to teach those skills necessary for each student to actively participate in home and community settings. Each student has an individualized educational program developed collaboratively with staff, family, and involved agencies. All of our programs incorporate the use of general education core areas and CAPA Blueprints. We are devoted to offering a positive, challenging and functional education to all of our students in the least restrictive enviornment. At the heart of our educational philosophy are encouragement, compassion, and respect, which enable each student to become as independent as possible.

ELIGIBILTY GUIDELINES

A. CRITERIA FOR MODERATE/SEVERE DISABILITES PROGRAM:
Must have eligibility of ID *(Intellectual Disability)*

1. In general, cognitive, adaptive, and academic skills within the moderate/severe range (standard scores below"55")
2. When scores are reported in age levels, these scores are within the moderate/severe range (less than half of the student's chronological age)

B. SUGGESTED AREAS OF ASSESSMENT:

1. Cognitive
2. Health and Development (including Vision/Hearing)
3. Adaptive Behavior / Skills
4. Communicative Development (Speech / Language)
5. Social / Emotional / Behavioral
6. Academic / Pre-Academic Achievement

Please check box below for which SD Program you are applying for:

☐ SD Ages (3-18) ☐ SD Post High School (Adult Transition Program/ATP)

If referring to the Adult Transition Program, is it for the current school year _____ or the upcoming school year _____ ? *(please check one)*
Applications for the upcoming school year must be submitted by **March 1st.**

Student Name: _____ Date of Birth: _____

Referring District: _____ Date: _____

C. THE APPLICATION MUST INCLUDE THE FOLLOWING REQUIRED DOCUMENTS:

☐ **IEP-** MUST BE CURRENT WITHIN THE LAST YEAR **(INCLUDING** *PROGRESS REPORTS* AND BEHAVIOR SUPPORT PLAN)

☐ **PSYCHOEDUCATIONAL REPORT-** MUST BE CURRENT WITHIN THE LAST 3 YEARS (INCLUDING HIGH SCHOOL STUDENTS)
☐ **PRESCHOOL REPORT -** WITHIN LAST 6 MONTHS, OR WITHIN THE LAST 12 MONTHS IF IT INCLUDES ANECDOTAL/UPDATED INFORMATION

☐ **HEALTH REPORT-** MUST BE CURRENT WITHIN THE SCHOOL YEAR AND COMPLETED BY A CREDENTIALED SCHOOL NURSE OR INCLUDE COMPREHENSIVE HEALTH HISTORY FROM STUDENT'S PHYSICIAN. ***(PLEASE INCLUDE COPY OF IMMUNIZATION RECORD)***

☐ **SPEECH EVALUATION -** IF APPROPRIATE WITHIN THE LAST 3 YEARS

☐ **OTHER** RELEVANT REPORTS / CVRC, EPU, etc....

REFERRING DISTRICT:

District of Residence : _____ Date: _____

Referred by: _____ Telephone: _____

Email address: _____ Best Time to Contact: _____

LEA Rep/Administrative designee: _____ Telephone: _____

Email address: _____ Best Time to Contact: _____

CURRENT STUDENT INFORMATION:

Student Name: _____ **Date of Birth:** _____

**Living with:* ☐ Parent /Guardian (s) ☐ Foster Care ☐ LCI ☐ Adult Student

Name of Parent/Guardian(s) _____

Address: _____ CITY: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name of Careprovider: _____

Address: _____ CITY: _____ Zip Code: _____

Telephone: _____

ED Rights Held By:
Name: _____

☐ Proof of Ed Rights holder (please attach copy)

CVRC Case Worker: (This will be in IEP)

Name: _____ Phone: _____ E-mail: _____

DESCRIPTION OF EDUCATIONAL SETTING:

Current School of Attendance: _____ Current Program: _____

History of Educational / Agency Services

Date	Age/Grade	School	Services

Student has: ☐ BSP ☐ Health Plan ☐ Special Health Procedures ☐ Transportation ESY ☐ No ☐ Yes

History of Cognitive Testing Results

Test	Date of Administration	Domain	Score

FUNCTIONAL SKILLS CHECKLIST:

Mobility/Fitness:

Wheelchair: ☐ Y ☐ N Able to bear weight: ☐ Y ☐ N Able to transfer: ☐ Y ☐ N

Sits Unassisted: ☐ Y ☐ N Stands Unassisted: ☐ Y ☐ N Crawls/ Creeps: ☐ Y ☐ N

Walks Unassisted: ☐ Y ☐ N

Communication/Language:

Functional Communication: ☐ Y ☐ N Single Words: ☐ Y ☐ N 2-3 word sentences: ☐ Y ☐ N

Complex sentences: ☐ Y ☐ N Sign language: ☐ Y ☐ N Gestures: ☐ Y ☐ N

PECS or other picture communication: ☐ Y ☐ N

Communication Device: ☐ Y ☐ N *Please describe:* _____

_____

Health:

Specialized health care procedures in place: ☐ Y ☐ N *Please describe:* _____

_____

Medications required at school: ☐ Y ☐ N *Please list:* _____

_____

Medications required at home: ☐ Y ☐ N *Please list:* _____

_____

Personal Management (bathroom use/meals/transitions/follows schedule, etc.):

Feeds self: ☐ Y ☐ N Eats with assistance: ☐ Y ☐ N Bottle-fed: ☐ Y ☐ N

Tube-fed: ☐ Y ☐ N Requires diaper (not trained): ☐ Y ☐ N

Toilets Independently or w/minimal assistance: ☐ Y ☐ N

Safety is a concern: ☐ Y ☐ N

Level of support: ☐ Direct supervision ☐ Can be monitored ☐ Dependable and independent during day

Specialized equipment: ☐ Y ☐ N *Specify:* _____

_____

Additional staff support is needed at school and/or in transit: ☐ Y ☐ N *Please describe:* _____

_____

Social/Emotional/Behavioral:

Level of support: ☐ Direct supervision at all times ☐ Can be monitored ☐ Dependable and independent during day

Behavior support plan in place: ☐ Y ☐ N Safety is a concern: ☐ Y ☐ N *If Yes, please describe:* _____

_____

PERSONAL DATA / HISTORY HEALTH INFORMATION

Form should be completed by a credentialed school nurse or indicate comprehensive health history from student's physician.

STUDENT DATA	LAST	FIRST	MIDDLE

BIRTHDATE	SEX	GRADE	BIRTH PLACE	LENGTH OF TIME USA/STATE/CO.

RESIDENCE	TELEPHONE: MESSAGE PHONE:

DATE MOVED TO PRESENT ADDRESS Month/Year ☐ LEP ☐ FEP ☐ Migrant	MARRIED STATUS OF PARENT ☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Other

FATHER'S NAME	AGE	BIRTHPLACE	EDUCATION

MOTHER'S NAME	AGE	BIRTHPLACE	EDUCATION

AGRICULTURE/AGRICULTURE-RELATED JOB ☐ Yes ☐ No	FATHER'S OCCUPATION	MOTHER'S OCCUPATION

SCHOOL HISTORY

Including the present school, list in chronological order the following:

STATE/COUNTY	DISTRICT	SCHOOL SITE	PLACEMENTS / PROGRAMS	LENGTH IN PROGRAM

GRADES REPEATED	SCHOOL ATTENDANCE ☐ GOOD ☐ FAIR ☐ POOR *(Explain "Fair" to "Poor" ratings)*

YOUR EDUCATIONAL CONCERN(S) ABOUT THIS CHILD IS?

WHAT DO YOU ENJOY MOST ABOUT THIS CHILD?

FAMILY HISTORY

STUDENT IS: (1st Born. etc,)	NUMBER OF BROTHERS ?	NUMBER OF SISTERS ?	LENGTH IN PROGRAM

FATHER'S AND MOTHER'S GENERAL HEALTH?

SIBLINGS: Name	BIRTHDATE	HEALTH

LEARNING PROBLEMS/SPECIAL EDUCATION HX: Parents, Siblings, and Other Family Members

STUDENT'S HISTORY

MOTHER'S AGE/HEALTH/MEDICATION/SUBSTANCE AND TOBACCO USE DURING THIS PREGNANCY:

BIRTH TERM	BIRTH WEIGHT

LABOR DELIVERY ☐ Anethesia ☐ Cesarean ☐ Prolonged Labor ☐ Mal-Presentation, etc. (Check and explain)

BIRTH HISTORY: ☐ Cry ☐ Color ☐ Respiration ☐ Injection ☐ Transfusion ☐ Incubation ☐ Jaundice ☐ Resuscitation ☐ Post Maturity ☐ Prematurity ☐ Anomalies ☐ Other (check and explain)

DIFFERENT THAN OTHER BABIES: Explain

NAME: _____ **BIRTHDATE:** _____

Prefer section be completed by a credentialed school nurse or include comprehensive health history from Student's physician.

DEVELOPMENTAL HISTORY

Enter Age; or check ( ) if unusual or explain

CRAWLED:	SAT:	WALKED:	FIRST WORDS:	PHRASES:	FED SELF:	TOILET-TRAINED:	BLADDER-TRAINED:	DENTAL:	COORDINATION:

GETTING ALONG:	UNUSUAL ATTITUDES:	DESTRUCTIVE/UNUSUAL BEHAVIOR:	AGGRESIVE BEHAVIOR:	EXTREME FEARS:	WITHDRAWN:	HYPERACTIVE:	HAND-DOMINANCE:

OTHER:

COMPARED TO OTHER CHILDREN, THIS CHILD IS:

HEALTH SCREENING/PROGRAMS/AGENCIES

NAME OF PRIMARY DOCTOR:

VISION TEST DATE: RESULTS:

HEARING TEST DATE: RESULTS:

HEIGHT: WEIGHT: HEAD:

IMMUNIZATIONS: (*Include a copy*)

IF THERE IS A PROBLEM, CHECK THE KEY WORD(S) AND ENTER NUMBER(S), DATES(S), DIAGNOSIS, RECOMMENDATIONS, AND THE MEDICAL DOCTOR(S) OR AGENCY(IES) CARE:

☐ (1) EENT ☐ (2) Orthopedic ☐ (3) G.U. ☐ (4) Respiratory ☐ (5) Circulatory ☐ (6) Endocrine ☐ (7) Connective Tissue ☐ (8) Neuromuscular
☐ (9) Genetic/Chromosome Problems ☐ (10) Skin ☐ (11) Nutrition ☐ (12) Poisoning ☐ (13) Allergies ☐ (14) Convulsions ☐ (15) Chronic Recurring Conditions
☐ (16) Serious Illness ☐ (17) Injuries ☐ (18) Medication(s) ☐ (19) Operation(s) ☐ (20) Hospitalization(s) ☐ (21) Equipment, Hardware, Other Aids ☐ (22) Special Needs
☐ (23) Other: _____

HISTORY INFORMATION RELIABLE? ☐ YES ☐ NO

REASON: ☐ Foster Care ☐ Child not with Parents ☐ Other

DO YOU FEEL AS THOUGH THIS CHILD'S HEALTH IS: ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor (check one)

HOME-FAMILY REALTIONSHIP

DESCRIBE PHYSICAL AND EMOTIONAL CLIMATE OF HOME, INCLUDING NURTURING, ACCEPTANCE, THE PHYSICAL PLANT, WHO LIVES IN HOME, ETC.

_____ _____

INTERVIEWEE'S NAME AND RELATIONSHIP STUDENT PERSON INTERVIEWING

INTERPRETER USED: LANGUAGED USED: DATE / POSITION

☐ YES ☐ NO _____ _____

MODERATE/SEVERE DISABILITIES PROGRAM SIGNATURE OF CONSENT FORM:

Dear Parents/Guardians

Your child is being referred to the ***Moderate/Severe Disabilities*** program operated by the Fresno County Office of Education Special Education Department. Prior to your child being considered for placement in ***Moderate/Severe Disabilities*** program, you must sign and date this form, which will become part of the referral packet. Signing this form only allows the school district to refer your child for consideration of placement in the ***Moderate/Severe Disabilities*** program.

Please know that, as the student's parents/guardians:

- You will be invited to be present at the Individualized Education Program Team Meeting to make a placement decision; and
- You will be contacted in advance of the Individualized Education Program Team Meeting date, and notified of the time and place of the IEP Team meeting; and
- Your child will not be placed in the ***Moderate/Severe Disabilities*** program without your written consent; and
- If home-to-school transportation is required, it will be provided to and from your child's home district (i.e. your child's district of residence and the program.

If you would like your child to be considered for placement in the FCOE program, please sign and date the form below, and return it to your child's teacher so that it can be included in the referral packet. If you have a question about this form or the referral process, please speak with your child's teacher.

We, the undersigned parents or guardians, hereby request that the Fresno County Superintendent of Schools, or designated representative, give consideration to the placement of our child,

Name of Student: _____ *Date of Birth:* _____

in the Moderate/Severe Disabilities program operated by the Fresno County Superintendent of Schools/Fresno County Office of Education, in accordance with provisions of the California State Education Code.

☐ Parent ☐ Guardian ☐ Surrogate ☐ Adult Student

Signature: _____

Date: _____

SIGNATURE OF LEA REPRESENTATIVE:

Name: _____ Date: _____

Title: _____ District: _____

Phone: _____ Email address: _____

Mail or fax application packet to Fresno County Office of Education, Attention Pupil Personnel Services Director
1111 Van Ness, Fresno, CA 93721 - **FAX# 559-237-3012**
Questions? Call 265-3001