Your Educational Partner of Choice
BOCES 2
Monroe 2 - Orleans Board of Cooperative Educational Services

REQUEST FOR SPECIAL EDUCATION SUPPORT SERVICES EVALUATION / INITIAL SERVICE (89F)

Student's Legal Name: _____ DOB: _____ Grade: _____ Pronouns Used: _____

Student is Also Known As: _____ Classified: ☐ Yes ☐ No ☐ 504 Plan

Home School District: _____ Billing District: _____

Referred by: _____ Position: _____ Date: _____

Teacher: _____ Location (Building/District): _____

Current District Program:
☐ In-District
☐ Parentally Placed
☐ District Placed

or, Current BOCES Program:
☐ Preschool Integrated
☐ Preschool 8:1:3
☐ 6:1:2 ASD
☐ 6:1:1 Behavior Mgmt.
☐ 6:1:1 Medically Fragile
☐ 8:1:1 CaSS
☐ 8:1:2 Intensive Mgmt.
☐ 6:1:2 Complex Needs
☐ 6:1:1 Center-Based
☐ 12:1:1 / 12:1:2
☐ Transition (12:1:1/6:1:1)
☐ Project SEARCH

Parent(s)/Guardian(s): _____ Home Phone: _____

Address: _____ Cell Phone: _____

_____ Work Phone: _____

1. **Check requested:** ☐ Student Evaluation and/or ☐ District Service Request For ☐ Current or ☐ Upcoming School Year

FOR NON-BOCES STUDENTS, PLEASE SHARE A CURRENT IEP AND OTHER RELEVANT INFORMATION

☐ Assistive Technology
☐ Counseling
☐ Occupational Therapy
☐ Psychological
☐ Vocational Assessment
☐ Audiology
☐ Hearing Impaired/TOD
☐ Orientation & Mobility
☐ Transition Services
☐ Work-Based Learning
☐ Autism Specialist
☐ Functional Behavior Assessment
☐ Physical Therapy
☐ Speech/Language
☐ Other: _____
☐ Consultant Teacher
☐ Music Therapy
☐ Psychiatric
☐ Vision

2. **Reason for referral:** Provide specific information as to the purpose of this request in box below
☐ For district-initiated evaluation requests, the "BOCES 2 Initial/Evaluation Request Summary" must be completed – see attached

3. **Reevaluation Consideration:** ☐ The team has reviewed the student and is not recommending any further evaluations at this time. (No Reevaluation)

4. **Person who contacted parent:** _____ Date: _____

Parents must be informed prior to any referrals for support services. Written parent consent must be obtained to initiate evaluation/service.

CSE Signature: _____ Date: _____ ☐ Approve ☐ Denied ☐ Implement Standard Reeval procedures
Parent Consent: ☐ Attached ☐ To be obtained (forward to BOCES when received)
Program Supervisor *(initials)*: _____ Date: _____ ☐ Approve ☐ Denied Comments: _____
Department Chairperson *(initials)*: _____ Date: _____ Support Staff Member Assigned: _____

Support Staff Member *(initials)*: _____ Date: _____ Action Taken: ☐ Evaluation Completed
Recommendation: _____ ☐ Other: _____

Attach Evaluation. If services are recommended for a classified student, also attach proposed IEP Proposed Amendment.

Department Chairperson *(initials)*: _____ Date: _____ Support Staff Member Assigned: _____
Program Supervisor *(initials)*: _____ Date: _____ ☐ Approve ☐ Denied Outcome Comments: _____
_____

Copy:
☐ Office File _____
☐ Program Supervisor _____
☐ Department Chairperson _____
☐ PPS Director _____
☐ Support Staff Member _____
☐ Teacher/Referring Source _____
☐ Records _____
☐ Other _____