Application Process for Placement/Services

(to be completed by the Home District)

School District: _____Contact Person:_____ School Year:_____

Student: _____DOB:_____ Grade:_____ Grade 9/Cohort Year: _____

Dist ID #:_____**STAC #**_____ Race:_____ Ethnicity: Hisp/Lat? (circle one) **Y/N**

Parent/Guardian 1:_____Cell Phone #:_____ Guardian Work#:_____

Parent/Guardian 2:_____Cell Phone #:_____ Guardian Work #:_____

Address:_____ Home Phone #: _____

_____

Emergency Contact:_____Phone #: _____

Diploma Type:_____ Number of Credits:_____ 504: _____ IEP:_____ Classification :_____
(Attach Transcript for HS student)

Program Requested (Please check)

12:1:1	**8:1:2**	**8:1:1**	**6:1:2**	**12:1:4**
___ Workstudy	___ Autism	___ Day Treatment*	___ SED	___ SMD
___ Workstudy (1/2 day)				

**attach DSM1V Axis diagnosis from a MD and/or licensed mental health professional)*

Indicate AM or PM

CTE Resource: ___ Resource Assistant (for test/program accommodations) OR ___ x30 min Resource/Consultant Teacher Services (push in or pull out)

Related Services Requested **(Please check and complete)** Frequency per week (unless otherwise noted)

Audiology
- Individual ____per ____
- Consult ____per year
- Aud Evaluation ___
- APD Evaluation ___

Deaf & Hearing Impaired Services
- Individual ____per ____
- Group ____per ____
- Consult ____per year
- CEAT Evaluation ___

Physical Therapy
- Individual ____per ____
- Group ____per ____
- Consult ____per year
- Evaluation ___

Visually Impaired Services
- Individual ____per ____
- Group ____per ____
- Consult ____per year
- Evaluation ___

Orientation & Mobility Services
- Individual ____per ____
- Group ____per ____
- Consult ____per year
- Evaluation ___

Counseling
- Individual ____per ____
- Group ____per ____

Consult ____per year
- Evaluation ___

Occupational Therapy
- Individual ____per ____
- Group ____per ____
- Consult _____per year
- Evaluation ___

Speech Therapy Indicate Medicaid Documentation Needed? **Yes/No**
- Individual ____per ____
- Group ____per ____
- Consult _____per year
- Evaluation ___

Additional Assistance
- ___ Teaching Assistant
- ___ Sign Language Interpreter
- ___ Teacher Aide (non-instructional)
- ___ TA/Captionist
- ___ per week -Job Coaching
- ___ per day -Skilled Nursing Services
- ___ per week -APE

Day Treatment Transitional Services
- BSP (# of days) _____
- Clinical (# of hours) _____

_____ _____ _____ _____

Chairperson, Committee on Special Education Date Superintendent (or Designee) Date

BOCES Office Use Only:

Date received: _____ *Date Effective:* _____*Date of Staff Notification:* _____

BOCES Admin: _____*Teacher(s):* _____

Related Service Staff: _____

*Other:*_____*Student Records Clerk:* _____ *Date Entered into Student Records:* _____