

2019-2020 School Year

**STUDENT SERVICES, ALTERNATIVE EDUCATION OR RELATED SERVICE
REFERRALS**

Alternative Education Referrals: Please complete this page then proceed to page 3 to complete more in-depth information requested for this placement.

Student Name _____ Date of Birth _____
(First, Middle, Last)

District of Residence _____ Grade _____

Student Address _____

City _____ Zip _____ County of Residence _____

City of Birth _____ Native Language _____

Primary Parent/Guardian _____ Parent/Guardian Phone _____
(Daytime only)

Name of Referral Source _____

Phone _____ Date of Referral _____ email _____

Teacher Contact _____ Building _____

School Personnel: please note, the next *five* sections are *required* elements for *all* referrals to any ESC program.

A. Local Ethnicity:

- A – Asian
- B – Black, Non-Hispanic
- H – Hispanic
- I – American Indian / Alaskan
- M – Multiracial*
- W – White, Non-Hispanic

B. Racial Groups: (Check all that apply)

- A – Asian
- B – Black / African American
- I – American Indian / Alaska Native
- P – Native Hawaiian / Other Pacific Islander
- W – White

**If Multiracial is selected, please be sure to select all racial groups that apply in box B.*

C. Hispanic / Latino:

- Yes, this student is Hispanic/Latino.
- No, this student is not Hispanic/Latino

D. Gender:

- Male Age: _____
- Female

E. Student Homeless Status: (Check One)

- * - Not Applicable
- A - Sheltered
- B - Unsheltered
- C - Doubled Up
- I - Hotel/Motel

F. Living with Student:

- Both Natural Parents
- Mother Only
- Father Only
- Mother + Other Adult
- Father + Other Adult
- Legal Guardian(s)* Yes ___ No ___
- Foster Parent(s)*

G. Student Homeless Unaccompanied Youth:

A homeless student not in the custody of a parent or guardian. (Check One)

- * - Not Applicable (*Used only if * was reported in box F*)
- N - No
- Y - Yes

H. Please include these documents with referral:

- Current ETR
- Current IEP
- HS Transcripts (if applicable)
- Parental Consent for Evaluation
- Prior Written Notice-optional
- Birth Certificate

Needed for Preschool Placement

- Immunization records
- Preschool Poverty Letter

*****Referrals will not be processed without these documents*****

I. Additional Components of Packet (If applicable)

- Achievement and OGT scores
- Behavior Plan
- Other

J. Preschool Special Education Services Requested:

- Center Based
- Itinerant
- DD IEP Only
- Speech-Language Pathology (SLP) Evaluation Only
- Occupational Therapy (OT) Evaluation Only

K. Instructional Services Requested

- | | | |
|--|---|--------------------------------|
| <input type="checkbox"/> Campus-Based Transition (CBT) | <input type="checkbox"/> Ventures II (Columbus) | <i>* HI – Hearing Impaired</i> |
| <input type="checkbox"/> Project Plus | <input type="checkbox"/> Deaf/ HH <i>*HI; **H, M, L</i> | <i>(H) – 100% in Classroom</i> |
| <input type="checkbox"/> Wings | <input type="checkbox"/> ED <i>*H, M, L</i> | <i>(M) – 50% in Classroom</i> |
| <input type="checkbox"/> STEP | <input type="checkbox"/> Low Incidence (<i>MD</i>) | <i>(L) – 25% in Classroom</i> |
| <input type="checkbox"/> STRIVE | <input type="checkbox"/> STACK | |
| <input type="checkbox"/> Ventures Academy (Delaware) | | |

L. Related Services Requested

- | | |
|---|--|
| <input type="checkbox"/> APE | <input type="checkbox"/> Physical Therapy (PT) |
| <input type="checkbox"/> Behavior Evaluation | <input type="checkbox"/> Speech-Language Pathology (SLP) |
| <input type="checkbox"/> Behavior Intervention Services | <input type="checkbox"/> Transition Services |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> VI Services |
| <input type="checkbox"/> Orientation and Mobility (O&M) | <input type="checkbox"/> VI Evaluation (Physician Documentation) |
| <input type="checkbox"/> Occupational Therapy (OT) | <input type="checkbox"/> Psychologist |
| | <input type="checkbox"/> Other |

M. Economically Disadvantagement (ED) Status:

- *=Not Applicable
- 1=Economic Disadvantagement

N. Limited English Proficiency (LEP) Status:

- N=No - the student is not Limited English Proficient
- Y=Yes - Limited English Proficient student who has been enrolled in US schools for more than 360 school days (or the equivalent of two school years)
- L=LEP – Enrolled in US Schools for First Time
- S=LEP – Enrolled in US Schools for Second Year (A recently arrived LEP student who has been enrolled in US schools for more than 180 school days and less than 360 days (or the equivalent of two school years).

BEHAVIOR INTERVENTION REFERRAL INFORMATION

This section required for Behavior Intervention referrals ONLY.

Specific information needed for Behavior Services:

- Individual Direct Behavioral/Mental Health Services *(listed as related service on IEP)*
- Individual Consultative Behavioral/Mental Health Services *(listed as related service on IEP)*
- Classroom/Team Consultative Services
- Development of Behavior Plan or Functional Behavioral Assessment
- Other _____

Referral packet for Behavior Services should include:

- Current IEP
- Behavior Plan *(necessary for Individual Direct or Consultative Services)*
- Quantitative Data *(frequency, duration, intensity)*
- Behavioral Observation Notes *(necessary for any behavioral services)*
- Other _____

ALTERNATIVE EDUCATIONAL REFERRAL INFORMATION

[Ventures Academy, Ventures II]

This section required for Alternative Education Programs ONLY.

Student Name: _____

School Attended: _____

Ventures Academy

Arts Academy

Ventures II

Does the student have an IEP? Yes No **If Yes, IEP Date: _____

Discipline Records: Yes No

Referral court documents: Yes No

Foster placed: Yes No

Current IEP and ETR needed, if applicable.

Reason(s) for referring this student to an Alternative Education Program *(Check all that apply)*

- | | |
|--|---|
| <input type="checkbox"/> Disruptive Behavior | <input type="checkbox"/> Expelled from School |
| <input type="checkbox"/> Truancy | <input type="checkbox"/> Alternative to Expulsion |
| <input type="checkbox"/> Suspended from School | <input type="checkbox"/> Other: _____ |
| # of Days Suspended: _____ | |
| <input type="checkbox"/> Alternative to Suspension | |

Delinquency: *(Check all that apply. Circle any having current Juvenile Justice Involvement)*

- | | |
|--|--|
| <input type="checkbox"/> Felony Offender | <input type="checkbox"/> Misdemeanant |
| <input type="checkbox"/> Status Offender | <input type="checkbox"/> Charges pending |

In the past year, has this youth received any special services at the school?

Mental Health/Counseling: Yes No

Alcohol/Other Drug Services: Yes No

Other In-School Services: *(e.g.: vocational education, tutoring, speech therapy, in-class aide, adaptive PE)* Yes No

If Yes, please describe: _____

In the past year, has this student received any special service outside of school?

Mental Health/Counseling: Yes No

If Yes, please describe: _____

Has the student had inpatient or residential MH treatment in the past year?

Yes No

If Yes, where: _____

Alcohol/Other Drug Services: Yes No

If Yes, please describe: _____

Child Protection Services: Yes No

If Yes, please describe: _____

If Yes, has the student been removed from the home in the past year? Yes No

Has the student had Legal System Involvement? Yes No

If Yes, indicate court penalty:

- Awaiting judgment Allowed at home without supervision
- DYS placement/jailed Probation, released
- Probation, active

Probation Officer's Name and Phone:

Does this student have any medical needs/conditions? Yes No

If Yes, please specify: _____

Does this student take medication daily? Yes No

Medication and dosage: _____

Name of prescribing physician/psychiatrist: _____

N/A Yes No Area of Concern within the past year (if Yes, rate level of concern as: 1 - Mild; 2 - Moderate; 3 - Serious)

- Peer Relationship: lacks long-term friendships and peer supports
- Peer Relationship: "hangs out" with "misbehaving" peers
- School Tardiness/Truancy: for serious truancy, circle one [per SB181-Habitual/Chronic]
- Verbally Aggressive/Inappropriate with (circle all that apply): Teachers / Peers / Parent figures
- Physically Aggressive/Inappropriate with (circle all that apply): Teachers / Peers / Parent figures
- Dangerous Behavior Toward (circle all that apply): Teachers / Peers / Parents / Self
- Chemical Use or Dependency: **Alcohol:** Admits Denies
Drugs: Admits Denies
- Perpetrator of abusive behavior (circle): Physical / Sexual
- Victim of abusive behavior (circle): Physical / Sexual

Describe the misbehaviors student is displaying at school:

What efforts have been tried to improve this youth's behavior at school?

What has been the parent/guardian's involvement and level of collaboration?

Is there other pertinent information the Alternative Program should know about?

OHIO GRADUATION TESTS

(Indicate which tests were passed or attempted)

- | | | |
|--------------------|---------------------------------|------------------------------------|
| Math | <input type="checkbox"/> Passed | <input type="checkbox"/> Attempted |
| Citizenship | <input type="checkbox"/> Passed | <input type="checkbox"/> Attempted |
| Reading | <input type="checkbox"/> Passed | <input type="checkbox"/> Attempted |
| Writing | <input type="checkbox"/> Passed | <input type="checkbox"/> Attempted |
| Science | <input type="checkbox"/> Passed | <input type="checkbox"/> Attempted |

Signature of Referring Agent: _____

Telephone Numbers: _____

Date: _____

Submit referral to Joyce Ellis

Email: referrals@escoco.org | Fax: (614) 542.4194

Educational Service Center of Central Ohio
2080 Citygate Drive | Columbus, OH 43219