

## CENTER PROGRAM REFERRAL

639 Oak Street • Wyandotte • Michigan • 48192 • Telephone (734) 759-6000

Attached are necessary documents and information required to complete a student lateral transfer or student referral. Intake Coordinator information and school addresses and telephone numbers are indicated below:

### SPECIAL EDUCATION – CENTER PROGRAMS

- **Madison** 4460 18<sup>th</sup> Street Telephone Number: (734) 759-6401
- **Lincoln Center** 891 Goddard Road Telephone Number: (734) 759-5901
- **Jo Brighton** 4460 18<sup>th</sup> Street Telephone Number: (734) 759-6301
  
- **Intake Coordinator for Lincoln Center:**  
Bill Bolton, Center Program Supervisor  
[boltonw@wy.k12.mi.us](mailto:boltonw@wy.k12.mi.us)  
Phone (313) 551-2790 x9219  
Fax (734) 759-5909
  
- **Intake Coordinator for Madison and Jo Brighton:**  
Katie Bradd, Center Program Supervisor  
[braddk@wy.k12.mi.us](mailto:braddk@wy.k12.mi.us)  
Phone (734)-759-6329  
Fax (734)-759-6409

### LATERAL TRANSFERS

The sending district must provide the following documents:

- Proof of Residency Verification Statement
- Current IEP that places the student in a center based program

The sending district is asked to provide the following documents as soon as possible:

- Any additional current documents
- Authorization for Release of Student Information from signed by the parent/guardian
- Birth Certificate copy
- Immunization records or waiver

### REFERRAL STUDENTS

#### **REVIEW OF RECORDS**

The sending district must provide current and required documents. The program administrator and intake coordinator will review documentation and contact the local school district representative making the referral.

#### **STUDENT OBSERVATION**

If the referral appears to be appropriate, arrangements will be made by Center Based staff to conduct an on-site visit for an observation of the prospective student.

#### **TOUR**

The Center Based staff will contact the sending district with the outcome of the Records Review/Student Observation. If enrollment at the Center appears to be an appropriate placement for the student, an appointment will be made with the parent/ guardian and sending district by the Center Based staff for their student to tour the appropriate center.

If the Center placement seems likely, the parent/guardian will be given the enrollment packet at the end of the tour. Enrollment documents may be completed at that time. Staff will need to see a copy of a CERTIFIED birth certificate.

#### **IEPT MEETING**

An IEPT meeting will be held with the sending district. The sending district will be responsible for ALL necessary paperwork required to complete the IEP. The Center Based staff will collaborate with the sending district at the IEP in developing the IEP. If it is a 3-year IEP the new REED and MET Summary Report with supporting reports must be included in the documentation. An entrance IEP will not be held until all required documents have been received.

#### **FINAL STEPS for ENROLLMENT**

The sending district will arrange transportation to begin on a mutually agreed upon date.

**NOTE: To guarantee sufficient processing time for student placement, please submit referrals for fall placement by May 15<sup>th</sup>.**

**Center Program**

**Proof of Residency Verification Statement**

New Student Referral Packet & Proof of Residency Verification Statement

Date of Referral

Desired Start Date

Referring District

School Placement

Student Name

Date of Birth

Address Number and Street Name – Apt. #

City

Zip Code

Parent/Guardian

Telephone Number

E-Mail

Address Number and Street Name – Apt. #

City

Zip Code

Is this student making a lateral transfer from a Center Based program:  Yes  No

Has the parent/guardian been notified that Wyandotte staff will observe the student?  Yes  No

Parent/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Sending District Contact Name

Telephone Number

E-Mail

**By signing below, the responsible district is indicating that they have all required Proof of Residency documents for the above named Center Program student.**

Signature of Responsible District Director of Special Education

Date

\_\_\_\_\_

*Please allow 2-4 weeks to complete referral process*

**HEALTH INFORMATION SURVEY TO BE COMPLETED BY THE PARENT/ GUARDIAN**

Student's Legal Last Name, First Name

Birth Date

Gender

School Year

### CHILD'S HEALTH CONCERNS

Asthma: Yes  No

Heart condition: Yes  No

Diabetes: Yes  No

Injuries/ Surgeries: Yes  No

Seizures: Yes  No

If yes, describe: \_\_\_\_\_

Allergies: Yes  No

\_\_\_\_\_

Other/ Comments/ Additional Information: \_\_\_\_\_

### MEDICATIONS

Medications: \_\_\_\_\_

Dose:

Times Taken:

Medications: \_\_\_\_\_

Dose:

Times Taken:

Medications: \_\_\_\_\_

Dose:

Times Taken:

Medications: \_\_\_\_\_

Dose:

Times Taken:

Medications: \_\_\_\_\_

Dose:

Times Taken:

Vision Screening Date: \_\_\_\_\_

Dental Visit Date: \_\_\_\_\_

Hearing Screening Date: \_\_\_\_\_

Physician

Telephone

Neurologist

Telephone

Psychologist

Telephone

Nursing Services

Telephone

Psychiatrist

Telephone

Other Specialist

Telephone

Other Specialist

Telephone

Case Manager / CMH Agency

Telephone

Other

Telephone

Is the student under a physician's ordered restriction?  No  Yes, if yes indicate reason below:

---

---

**NOTE:** This form is not a medication authorization form.

If your student will or may require medication at school, notify the intake coordinator.

Parent/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**REFERRAL SOURCE QUESTIONNAIRE TO BE COMPLETED BY REFERRING DISTRICT**

Student's Legal Last Name, First Name

Birth Date

Gender

School Year

In what way/s is the student independent? \_\_\_\_\_

In what way/s is the student dependent? \_\_\_\_\_

How does the student get along with other people? \_\_\_\_\_

Describe any student behavior/s that interfere with instruction, stigmatize or isolates the student or endangers the student or other people: \_\_\_\_\_

Has the student or their parent/s or guardian/s expressed any concerns regarding current or future educational issues: \_\_\_\_\_

Describe any special skills or interests that you observed: \_\_\_\_\_

Are there any issues regarding this student that you are particularly concerned? \_\_\_\_\_

Describe the student's communication abilities: \_\_\_\_\_

Other: \_\_\_\_\_

Is the student enrolled with School of Choice?  No  Yes

Have the student's parents or guardians been active in education planning?  No  Yes

Is the student identified as an English Language Learner?  No  Yes

- If yes, does the student receive service?  No  Yes

Is the student in a fixed, regular and adequate living environment?  No  Yes

Is the student a recipient of services under the McKinney-Vento Act?  No  Yes

**AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION**

**STUDENT NAME:**   
Last Name, First Name

**Birth date:**

**STUDENT NAME:**   
Last Name, First Name

**Birth date:**

**STUDENT NAME:**   
Last Name, First Name

**Birth date:**

**Request to disclose and/or release the following:**

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Academic          | <input checked="" type="checkbox"/> IEP                                      |
| <input checked="" type="checkbox"/> Discipline        | <input checked="" type="checkbox"/> Psychological Evaluation & Tests Results |
| <input checked="" type="checkbox"/> Health / Medical  | <input checked="" type="checkbox"/> M.E.T. Report                            |
| <input checked="" type="checkbox"/> Achievement Tests | <input checked="" type="checkbox"/> IEP Evaluation Review                    |
| <input checked="" type="checkbox"/> Social Work       | Other _____  |
| <input checked="" type="checkbox"/> Medical           | Other _____  |
| <input checked="" type="checkbox"/> 504 Plan          | Other _____  |

*In compliance with Family Educational Rights and Privacy Act, FERPA, the undersigned requests information relative to the above named student/s educational record/s to be **RELEASED TO:***

School Requesting Records:  Contact Name:

School Address: \_\_\_\_\_, Wyandotte, MI 48192

School Telephone Number:  School Fax Number:

*In compliance with Family Educational Rights and Privacy Act, FERPA, the undersigned requests information relative to the above named student/s educational record/s to be **RELEASED FROM:***

I, parent/guardian of the above named student/s, \_\_\_\_\_  
PARENT / GUARDIAN NAME - PLEASE PRINT

authorize the above named entity and its authorized employee to disclose and/or release any and all student record information related to the above named student/s to the person/entity identified above, I hereby agree to indemnify and hold harmless the Wyandotte Board of Education, and its officers, employees, and agents in both their individual and official capacities, from liability of any nature resulting from the disclosure/release of the information.

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian Address: \_\_\_\_\_

Student Name

Date of Birth

### REQUIRED DOCUMENTS:

- Copy of birth certificate (parent/ guardian must present original at tour / IEP)
- Copy of Student State ID, if applicable
- Center program referral packet
- Copy of driver's license of parent/ legal guardian
- Immunization records or waiver      Date of Record: \_\_\_\_\_
- IEP/ IFSP- most recent      Date of Record: \_\_\_\_\_
- REED- most recent      Date of Record: \_\_\_\_\_
- REED- associated with most recent MET      Date of Record: \_\_\_\_\_
- Psychological Evaluation- to include adaptive behavior assessment      Date of Record: \_\_\_\_\_
- MET- most recent and supporting reports listed below, as appropriate      Date of Record: \_\_\_\_\_
  - Teacher Report
  - Speech and Language Report
  - Social Work Report
  - Occupational Therapy Report
  - Physical Therapy Report
  - Medical Reports
  - Mental Health Reports / Psychiatric Reports
  - ENT / Audiologist Report
  - Vision Evaluation
  - Orientation and Mobility Evaluation

### REQUIRED IF APPLICABLE:

- Individualized Health Care Plan      Date of Record: \_\_\_\_\_
- Feeding plan      Date of Record: \_\_\_\_\_
- Seizure action plan and/ or asthma action plan      Date of Record: \_\_\_\_\_
- Functional Behavior Assessment \*      Date of Record: \_\_\_\_\_
- Behavior Intervention Plan\*      Date of Record: \_\_\_\_\_
- Behavior Specialist Report \*      Date of Record: \_\_\_\_\_
- Behavior Review Forms & Summarized Data\* (see WRESA Guidelines for Behavior Intervention)      Date of Record: \_\_\_\_\_
- MDR/ IAES      Date of Record: \_\_\_\_\_
- Discipline Summary (MiStar)      Date of Record: \_\_\_\_\_
- Transcripts      Date of Record: \_\_\_\_\_
- Statewide Assessment reports      Date of Record: \_\_\_\_\_
- Attendance records      Date of Record: \_\_\_\_\_
- COSF (required for any student under 5 years 6 months)      Date of Record: \_\_\_\_\_
- Court orders or placement papers (guardianship, power of attorney, custody, etc.)      Date of Record: \_\_\_\_\_
- Prescription(s) for related services      Date of Record: \_\_\_\_\_
- ASD Student Profile (required for referrals to ASD program)
- Physician's Recommendation for Homebound Instruction (this form can be requested directly from the Intake Coordinator)

\* These forms are required for all referrals to the ASD and DD programs