Livingston EDUCATIONAL SERVICE Agency

HOME-BASED EDUCATIONAL SERVICES REFERRAL

Referral Date: ____________ School Building: ______________________________

Student Name: ____

Birth Date: ________________ Gender: ☐ Male ☐ Female Grade: ______________

Special Ed. Eligibility:	☐ Does Not Apply	☐ ASD	☐ D-B	☐ EI	☐ OHI	☐ SCI	☐ SLI	☐ TBI
		☐ CI	☐ ECSE	☐ D/HH	☐ PI	☐ SLD	☐ SXI	☐ VI

Parent / Guardian: ________________________________ Phone: ______________

Address: ____

Student Schedule

Subject	Teacher & Teacher Email

Name of Person Making Referral: ____________________ Title: ____________________

Projected Duration: ____________ to ____________ ☐ Ongoing for FAPE purposes
(student is over 10-day cumulative suspension day threshold)

Amount of Time per Week: ______________________

Central Office Approval Signature: ______________________ Date: ____________
Required before services can begin *(includes approval of additional time for exams/testing/teacher consultation)*

Special Education Director Approval Signature: ______________________ Date: ____________
Required before services can begin

When completed, send to: Assistant Superintendent for Special Education c/o Carol Braden
Livingston Educational Service Agency
1425 W. Grand River Ave.
Howell, MI 48843 **Fax:** 517-546-7047 **Email:** CarolBraden@LivingstonESA.org

Date Received by Livingston ESA: ______________

Livingston ESA Approval: ______________________ Title: Asst. Superintendent for Special Education

Date Assigned: ______________ Assigned To: ______________________

Copies of completed form sent to: ☐ LEA Special Education Office ☐ LEA HR Special ☐ LEA Referring School