



Caesar Rodney School District Countywide Programs Program Referral

Please check the program which to which you are referring.

☐ Kent Elementary ILC

☐ Charlton School

I. **Sending District Information**

Student Name:

Student Address:

Student Date of Birth:

Parent/Guardian Contact Information:

- Does the student have an educational surrogate? ☐ Yes ☐ No
 - If yes, please provide contact information:
- Who has Parental Rights?
- Are there any restrictions related to custody to be aware of? ☐ Yes ☐ No
 - If yes, please describe and/or include paperwork:
- Is the student their own guardian (if 18 years old or older)? ☐ Yes ☐ No
 - If no, please provide guardianship paperwork with referral packet.

Sending District:

Attending School:

Current Grade:

Current LRE:

What is the reason for the potential Countywide Programs placement?

Staff Member Completing Application:

Staff Member Contact (Phone/E-mail):

Submit to the sending Director of Special Education for approval prior to submission to the CR Countywide Programs.

Signature of Sending Director of Special Education: _____ Date: _____



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The John S. Charlton School/Kent Elementary ILC is a highly structured program. This program utilizes certain behavior management techniques that are unique to this program and that may vary from those found in other levels of special education or regular education programs.

As parent/guardian, legally responsible for (student name) _____, I have been informed of, and understand:

- the differences between the John S. Charlton School/Kent Elementary ILC and other programs in which my child has been previously placed including the change in academic rigor and graduation requirements;
- the John S. Charlton School/Kent Elementary ILC staff are trained on Safe and Positive Approaches which may include, but are not limited to, removal from class or restraint to prevent harm to their self or others; and
- I agree with the use of this program as part of my child's educational programming.

Signature of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

II. Agency Involvement

Identify representatives of all agencies and service providers involved with the student. Specify the services provided (if any):

Agency	Yes	No	Referral in Progress/ Date	Service(s) Provided	Contact Name
DSCYF (PBH)	<input type="checkbox"/>	<input type="checkbox"/>			
DSCYF (DFS)	<input type="checkbox"/>	<input type="checkbox"/>			
DHSS (DSAMH)	<input type="checkbox"/>	<input type="checkbox"/>			
DHSS (DDDS)	<input type="checkbox"/>	<input type="checkbox"/>			
DHSS (DVI)	<input type="checkbox"/>	<input type="checkbox"/>			
DVR	<input type="checkbox"/>	<input type="checkbox"/>			
Private Service Provider	<input type="checkbox"/>	<input type="checkbox"/>			
Other:					



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III. **Current Interventions & Student Performance**

Identify the current interventions and student performance areas of concern as identified by assessment. Please include copies of the most recent assessments (teacher made and standardized) as available.

Subject/Skill Area	Instructional Level	As Assessed On

IV. **Medical Considerations**

- Does the student have any significant medical problems? ☐ Yes ☐ No
 - If yes, please describe:
- Does the student receive medication? ☐ Yes ☐ No
 - If yes, please describe:

V. **Progress of Individualized Education Program**

Provide a current IEP with meeting minutes including a transition plan for students ages 14 and older; Attach a behavior support plan and progress data; Note progress on previous IEP goals and note areas of inadequate progress including on report cards.

Describe and summarize the student's special education background as well as interventions and revisions made for student across their educational continuum.



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VI. Student Needs, Goals and Progress Utilizing Alternative Supports & Services

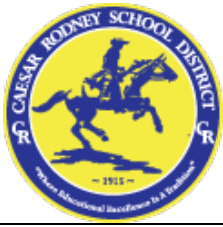
What are the students' individual needs? Based on the student needs, identify goals that are appropriate for utilization of unique alternative supports and services.

Type of Service	Yes	No	Frequency/Time	Areas of Need
Speech	<input type="checkbox"/>	<input type="checkbox"/>		
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>		
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		
Counseling	<input type="checkbox"/>	<input type="checkbox"/>		
Deaf-Blind Therapy	<input type="checkbox"/>	<input type="checkbox"/>		
Nursing	<input type="checkbox"/>	<input type="checkbox"/>		
Special Transportation	<input type="checkbox"/>	<input type="checkbox"/>		
Other:	<input type="checkbox"/>	<input type="checkbox"/>		

VII. Student Needs, Goals and Progress Utilizing Alternative Supports & Services

Referrals will be considered pending the attachment and receipt of all items listed below. Check (✓) if items are attached or, if not attached, state when they will be sent:

	Attached	Not Attached
Permission to Exchange Confidential Information/ Disclosure signed by the parents/guardian	<input type="checkbox"/>	<input type="checkbox"/>
If educational rights are held by anyone other than parent(s), provide copy of custody/educational surrogate, etc. documents; Include Age of Majority and Guardianship paperwork if appropriate	<input type="checkbox"/>	<input type="checkbox"/>
Discipline records	<input type="checkbox"/>	<input type="checkbox"/>
Copies of outside evaluations from agencies and/or related service providers that support this referral	<input type="checkbox"/>	<input type="checkbox"/>
Eligibility/Evaluation Report current within the last three (3) years (including the Psychological Evaluation Summary and related service	<input type="checkbox"/>	<input type="checkbox"/>



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	Attached	Not Attached
testing)		
Permission to Evaluate for the existing Evaluation Report	<input type="checkbox"/>	<input type="checkbox"/>
Current Complete IEP (inclusive of progress updates for goals attached, meeting minutes and prior written notice)	<input type="checkbox"/>	<input type="checkbox"/>
Current Behavior Plan/Safety Plan (must include Functional Behavior Assessments/Functional Analyses)	<input type="checkbox"/>	<input type="checkbox"/>
Data sheets/graphical summaries of behavioral intervention data, including plan implementation fidelity data	<input type="checkbox"/>	<input type="checkbox"/>
Any other relevant medical documentation (hearing/vision screenings, neurological reports, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

CWP Team Use Only: Submit accepted referral to the receiving Director of Student Services prior to student enrollment.

Signature of CR Director of Student Services: _____ Date: _____

<p><u>Please send John S. Charlton School Placement referral with all attachments to:</u> Referral Coordinator John S. Charlton School 278 Sorghum Mill Road Camden, DE; 19934 Phone: 302-697-3103</p>
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<p><u>Please send Kent Elementary ILC referral with all attachments to:</u> Referral Coordinator Kent Elementary ILC 5 Old North Road Wyoming, DE; 19934 Phone: 302-697-3504</p>
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