

PINELLAS COUNTY SCHOOLS
EXCEPTIONAL STUDENT EDUCATION (ESE) DEPARTMENT
ESE PRE-KINDERGARTEN TO KINDERGARTEN ARTICULATION CHECKLIST

Student: _____ DOB: _____ Most Recent IEP/Amendment Date: _____ Date Form Completed: _____

Current Pre-K School: _____ Current Pre-K Teacher: _____ Current FTSDC: _____

1. Current ESE Eligibility(s) (check all that apply)

- | | | | |
|---|---|--|---|
| ☐ C -Orthopedically Impaired | ☐ I -Visually Impaired | ☐ P -Autism Spectrum Disorder | ☐ T -Developmentally Delayed |
| ☐ F -Speech Impaired | ☐ J -Emotional/Behavioral Disabled | ☐ S -Traumatic Brain Injured | ☐ Cognitive Goal(s) |
| ☐ G -Language Impaired | ☐ K -Specific Learning Disabled | ☐ V -Other Health Impaired | ☐ Language Goal(s) |
| ☐ H -Deaf or Hard of Hearing | ☐ O -Dual-Sensory Impaired | ☐ W -Intellectual Disability | ☐ Adaptive Goal(s) |
| | | | ☐ Fine/Gross Motor Goal(s) |
| | | | ☐ Social/Emotional Goal(s) |

Related Services (check all that apply)

- ☐ D -Occupational Therapy ☐ E -Physical Therapy ☐ F -Speech Impaired ☐ G -Language Impaired

2. IEP Due Date: _____ **Reevaluation Due:** _____

Student Turns 6 years of age: _____ **Reevaluation Opened: _____ Reevaluation Closed: _____

3. Specialized Transportation Needs (check all that apply)

- | | | | |
|--|--|--|---|
| ☐ C -Unique Seating Device due to disability (car seat) | ☐ O -Oxygen | ☐ 1 - Stop Closest to Home | Additional Equipment:
☐ C -Car seat due to age or weight
☐ H -Harness due to age or weight |
| ☐ E -Crutches | ☐ P -Physician Prescribed Environment | ☐ 2 - Corner Stop Closest to Home | |
| ☐ F -Walker | ☐ T -Tracheotomy Equipment | | |
| ☐ H -Unique Positioning Device (harness) | ☐ U -Unique Seating Device (other) | | |
| ☐ M -Monitor for supervision/ support due to disability | ☐ W -Wheelchair | | |
| ☐ N -Nurse | | | |

4. Proposed Kindergarten Placement (check all that may apply)

- | | | |
|--|--|--|
| ☐ RE -Dismissal of all ESE Services, including consultation | ☐ I1 *In general education 50% or more for a Core Content with Access Standards | ☐ C1 **Center-based EBD services
☐ C2 **Center-based SVE services
☐ C3 **Center-based Participatory VE services
☐ C4 **Center-based ASD services
☐ C5 **Center-based Sensory Behavior |
| ☐ RP -Part-time Varying Exceptionalities | ☐ I3 *In general education 50% or more for a Core Content with EBD supports | |
| ☐ P2 -Speech/ Language therapy (SI/LI) | ☐ I5 *In general education 50% or more for a Core Content with Access Standards & ASD supports | |
| ☐ P3 -Part-time Deaf or Hard of Hearing (DHH) services | ☐ I6 *In general education 50% or more for a Core Content ASD supports | |
| ☐ P4 -Visually Impaired part-time services | ☐ S1 *Access Standards in ESE for 50% or more of <u>all core content</u> | |
| | ☐ F2 *Deaf or Hard of Hearing services in ESE for 50% or more of <u>all core content</u> | |
| | ☐ F3 *Emotional/ Behavioral Disabilities (EBD) services in ESE for 50% or more of <u>all core content</u> | |
| | ☐ F5 *Autism Spectrum Disorder (ASD) -Access Standards in ESE for 50% or more of <u>all core content</u> | |
| | ☐ F6 *ASD services in ESE for 50% or more of <u>all core content</u> | |

☐ **IEP Present Levels and Services support proposal ☐ **Reevaluation initiated ☐ **Center-based Staff involved in proposal

5. Medical / Adaptive Equipment to be transferred:

Asset Transfer Entered: _____ Bookkeeper's Initials

6. ☐ NA or Request for Additional Assistance submitted in RAA database: _____ Administrator Initials

Name of Administrator Signature of Administrator (REQUIRED) Date

Original - Staffing Folder Copy: ESE Pre-K Admin Office

FOR ESE PRE-K OFFICE USE ONLY

Verification of Service Delivery Code and School Assignment: _____ Date: _____

Copy: Receiving Principal Copy if applicable: OT/PT Coordinator SLP Coordinator DHH Coordinator VI Coordinator