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| **DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA**  **DESERT/MOUNTAIN CHARTER SPECIAL EDUCATION LOCAL PLAN AREA**  17800 HIGHWAY 18 • APPLE VALLEY, CA 92307  (760) 552-6700 • (760) 242-5363 FAX  **Administrative Transfer to SBCSS/District Program** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ADMINISTRATIVE TRANSFER TO:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **D/M OPERATIONS, SBCSS, FROM THE DISTRICT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **DISTRICT PROGRAM FROM D/M OPERATIONS, SBCSS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DIRECTIONS: PLEASE MARK THE APPROPRIATE BOX(ES). WHERE APPLICABLE, PROVIDE THE FOLLOWING INFORMATION AND/OR REQUIRED DOCUMENTATION. SIGN/DATE/FORWARD COMPLETED FORM AND AVAILABLE INFORMATION TO THE APPROPRIATE ADMINISTRATOR.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **STUDENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Student Name: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date of Birth: | | | | | | | | | | | |  | | | | | | | | | | | | | | | Grade: | | | | | |  | |
| District of Attendance: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | District of Residence: | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| School Site: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parent/Guardian: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | Home Phone: | | | | | | | |  | | | | | | | | | | | | | | | | | | Work Phone: | | | | | | | | | |  | | | | | | | | |
| Street Address: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | City: | | | | |  | | | | | | | | | | | | | | State: | | | | | | | |  | | | | | | | | Zip Code: | | | | | |  | | | |
| Mailing Address: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | City: | | | | |  | | | | | | | | | | | | | | State: | | | | | | | |  | | | | | | | | Zip Code: | | | | | |  | | | |
| Current Placement: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Transfer to (Special Education Program): | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | Refer to IEP dated: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
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| ***If Applicable:*** | | | | | | | | | | | | | | Foster Home/LCI  Community School/Juvenile Facility  Hospital | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Contact Phone: | | | | | | | | | | | |  | | | | | | | | | | |  |
| Name of Foster Parents/Contact Person: | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | Address: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Placing Agency: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Court Assignment of Education Rights to: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
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| 1. | IEP available/attached to this transfer request ***OR*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | All information obtained from previous district/placement via phone | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
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|  | *Current IEP Date:* | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | *Three-year Review Date:* | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
|  | *Describe the Nature of the Disability:* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | *Detail Instructional Setting:* | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | *Current Assessment(s) Attached (if applicable):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | *Psycho-educational* | | | | | | | | | | | | | | | | | | *Occupational Therapy* | | | | | | | | | | | | | | | | | | | *Adaptive P.E.* | | | | | | | | | | | | | *Speech and Language* | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | *Physical Therapy* | | | | | | | | | | | | | | | | | | *Behavior Support Plan* | | | | | | | | | | | | | | | | | | | *FAA/PBIP* | | | | | | | | | | | | | *Other:* | | | | | | | | | | |  | | | | | | | | | | | | | | | |
|  | *Present Levels of Performance:* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | *Academics:* | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | *Language:* | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | *Social/Emotional:* | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | *Physical:* | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | *Ambulatory:* | | | | | | *No* | | | | | *Yes* | | |
|  |  | | | | *Self-Help:* | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | *Pre-Vocational/Vocational:* | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | *Other:* | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | *Goal Areas:* | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | *Related Services:* | | | | | | | | | | | | | | | | | LSH  APE  Direct OT  Direct PT  Counseling  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| 2. | Medical/Physical Diagnosis: | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | *Significant Health Information (be specific) Medication:* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | *Seizures:* | | | | | | | *No* | | | | | | | | | | | *Yes, type:* | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | *Allergies:* | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
|  | *Special Feeding Needs:* | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | *Catheterization:* | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | *Wheelchair:* | | | | | | | | | | | | *No* | | | | | | | | | *Yes* | | | | | | | | | | *CCS Eligible:* | | | | | | | | | *No* | | | *Yes* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| 3. | Specialized Transportation Needs: | | | | | | | | | | | | | | | | | | | | | | | | | | N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | Current Immunization Records: | | | | | | | | | | | | | | | | | | | | | | | | | *Immunization Records Attached* ***OR*** | | | | | | | | | | | | | | | | | | | | | | | | *District Confirmation All Immunizations are Current* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | Confidential records including current psycho-educational evaluation enclosed to be returned to the district of residence. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **THIS REFERRAL AND ASSESSMENT WAS DISCUSSED WITH THE PARENT:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | *No* | | | | | | | | | | *Yes* | | | | | | |  | | | | | | | | | | | | |
| Date: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Administrator Signature: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |