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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: |       |
|  |
| ***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 |  |
|  |  |  | INITIAL |
|  | *Current IEP Date:* |       | *Three-year Review Date:* |       |
|  | *Describe the Nature of the Disability:* |       |
|  |       |
|  | *Detail Instructional Setting:* |       |
|  |       |
|  | *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: |  |