

ELIGIBILITY GUIDELINES & REFERRAL PROCESS

Moderate/Severe Disabilities Program –

A. CRITERIA FOR MODERATE/SEVERE DISABILITIES PROGRAM:

1. In general, cognitive, adaptive, and academic skills within the moderate/severe range (standard scores below “55”)
2. When scores are reported in age levels, these scores are within the moderate/severe range (less than half of the student’s chronological age)

B. SUGGESTED AREAS OF ASSESSMENT:

1. Cognitive
2. Health and Development (including Vision/Hearing)
3. Adaptive Behavior / Skills
4. Communicative Development (Speech / Language)
5. Social / Emotional / Behavioral
6. Academic / Pre-Academic Achievement

REFERRAL PROCESS

- For the Moderate to Severe Disabilities Program: (see flowchart)

Referral Process [Flowchart](#) (Excluding Interim Placements & Consideration for Adult Transition Program for district served seniors for the next school year)

- For additional information or questions regarding the FCOE Moderate Severe Disabilities Program please contact: Director, Pupil Personnel Services @ (559) 265-3001 or Director, Special Education @ 265-3051.
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FCOE Special Education Program Referral Application Checklist for: _____ [Student]
_____ [Date of Birth]

Referral packet must include the following:

- Current Individualized Education Plan (IEP pages 1a, 1b, 1c, and 2; IEP Meeting Notes, Behavior Plan, if any)
Date of Last IEP: _____ (must be within the last year)
- Assessment Information to be provided by staff listed below, e.g., psychologist, nurse, etc. Current version or comparable assessment test to be provided for each section below:

School Psychologist. Date of most recent Psychoeducational Report: _____

- Cognition, e.g., UNIT, C-TONI, WISC-IV, etc; non verbal/verbal cognitive
- Visual Processing, e.g., TVPS, VMI, etc.
- Social-emotional, e.g., BASC, SSRS, Achenbach, etc.
- ADD, if applicable, e.g., ADDES, Conners, etc.
- Adaptive, e.g., Vineland, Adaptive Behavioral Assessment System (ABAS), etc.
- Specific tests for diagnosis of autism, e.g., ADOS, medical report documenting autism diagnosis

Reports must meet stated guidelines of following programs:
Moderate/Severe – Report within the last 3 years.
Autism – Report within last 12 months.
Preschool – Report within last 6 months, or within the last 12 months if it includes anecdotal/ updated information.

Credentialed School Nurse.

- Personal Data/Health History Information Form (Form is found at pages 4 and 5)
or include comprehensive health history from Student's Physician
- Immunization Record, including TB test results
- Pertinent Medical Records, including vision and hearing test results
- Current, daily medications, include past medications, if applicable
- Developmental History from birth to age 5

Speech/Language Pathologist. Complete Speech and Language Assessment Report, including:

- Semantics, Syntax, Morphology, Pragmatics, Fluency, and Voice Evaluation
- Oro-facial examination
- Language sample, including mean length of utterance calculation, if applicable
- Classroom observation information
- Parent information related to speech and language development
- Dynamic assessment information, if applicable
- Play-based assessment, if applicable
- Bilingual assessment report, including CELDT information, if applicable
- Other recommended assessments include CASL, CELF, CREVT, CTOPP, EOWPVT, LPT, NON-SPEECH TEST, OWLS, PLS, PPVT, ROWPVT, SPELT, TAFL, TEEM, TOLD, TOPS, TOPL, and TOSS. This is not an exhaustive list of all assessment options. Note: use only the current version of any assessment tool.

General Education Teacher.

- Academic Information
- Behavior Information
- 504 Plan and/or all previous accommodations/modifications

Special Education Teacher.

- Assessment report, including complete test battery, e.g., Brigance, HAWAII, WIAT-II, KTEA, KSEALS (do not include screening test)
- Reading level
- Math level
- Spelling/written language level
- Writing sample
- Student work samples

Fresno County Office of Education Special Education Program Referral Application

Complete the following and send to Fresno County Office of Education:

STUDENT'S NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

TELEPHONE: _____

(City/Zip) _____

CSIS #: _____

PARENT(S)/GUARDIAN(S): _____

TELEPHONE: _____

ADDRESS: _____

(City/Zip) _____

CARE PROVIDER: _____

TELEPHONE: _____

ADDRESS: _____

(City/Zip) _____

REFERRING DISTRICT: _____

CURRENT PROGRAM: _____

DISTRICT CONTACT PERSON: _____

SCHOOL SITE: _____

DISTRICT REP FOR IEP MEETINGS: _____

TELEPHONE: _____

PRIOR DISTRICT: _____

TELEPHONE: _____

PRIOR DISTRICT CONTACT PERSON: _____

TELEPHONE: _____

Student's referral application is for the following FCOE program (check appropriate box):

- Moderate/Severe Disabilities Program (including Adult Transition Program for Current School year).** Mail or fax application packet to Fresno County Office of Education, Attention Pupil Personnel Services Director, 1111 Van Ness, Fresno, CA 93721, **FAX# (559) 237-3012.** Questions? Call (559) 265-3001.

- Emotionally Disturbed Program (E.D.).** Mail or fax application packet to Fresno County Office of Education, Attention Pupil Personnel Services Director, 1111 Van Ness, Fresno, CA 93721, **FAX# (559) 237-3012.** Questions? Call Tannon Pafford/East Side E.D. (559) 265-4033 or Sherrin Massie/West Side E.D. (559) 265-3039 or PPS Director at (559) 265-3001.

- CIRCLE Program** (Comprehensive Instruction Reinforcing Collaborative Learning Environments). Mail or fax application packet to Fresno County Office of Education, Attention CIRCLE Program Manager, 1111 Van Ness, Fresno, CA 93721, **FAX# (559) 265-3076.** Questions? Call: (559) 497-3708.

Application Completed By: _____

Date: _____

Title: _____

Telephone: _____

Email: _____

Best Time to Contact: _____

Dear Parents/Guardians:

Your child has been referred to a special education program operated by the Fresno County Office of Education Special Education Department. Prior to your child being considered for placement in an FCOE program, you must sign and date this form, which will become part of the referral packet. Signing this form only allows the school district to refer your child for consideration of placement in an FCOE program.

Please know that, as the student's parents/guardians:

- You will be invited to be present at the Individualized Education Program Team Meeting to make a placement decision; and
- You will be contacted in advance of the Individualized Education Program Team meeting date, and notified of the time and place of the IEP Team Meeting; and
- Your child will not be placed in an FCOE program without your written consent; and
- If home-to-school transportation is required, it will be provided to and from your child's home district (i.e. your child's district of residence) and the program.

If you would like your child to be considered for placement in an FCOE program, please sign and date the form below, and return it to your child's teacher so that it can be included in the referral packet. If you have a question about this form or the referral process, please speak with your child's teacher.

*We, the undersigned parents or guardians, hereby request that the Fresno County Superintendent of Schools, or designated representative, give consideration to the placement of our child, _____ **[name of student]**, _____ **[Date of Birth]**, in a special education program operated by the Fresno County Superintendent of Schools/Fresno County Office of Education, in accordance with provisions of the California State Education Code.*

Parent/Guardian

Parent/Guardian

Date

Date

PERSONAL DATA / HISTORY HEALTH INFORMATION

Form should be completed by a credentialed school nurse or include comprehensive health history from student's physician.

| | | | | | | | |
|---|--|---|------------------------------|---------------------|--------------------------|---|--|
| STUDENT DATA | | LAST | | FIRST | | MIDDLE | |
| BIRTHDATE | SEX | GRADE | BIRTH PLACE | | | LENGTH OF TIME: USA / STATE / CO. | |
| RESIDENCE | | | | | TELEPHONE: | | |
| DATE MOVED TO PRESENT ADDRESS: Month/Year | | | | | MESSAGE PHONE: | | |
| <input type="checkbox"/> LEP | | <input type="checkbox"/> FEP | | Migrant | | MARRIED STATUS OF PARENT: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Other | |
| FATHER'S NAME | | | AGE | BIRTH PLACE | | EDUCATION | |
| MOTHER'S NAME | | | AGE | BIRTH PLACE | | EDUCATION | |
| AGRICULTURE/AGRICULTURE-RELATED JOB <input type="checkbox"/> Yes <input type="checkbox"/> No | | FATHER'S OCCUPATION | | | MOTHER'S OCCUPATION | | |
| SCHOOL HISTORY | | <i>Including the present school, list in chronological order the following:</i> | | | | | |
| STATE/COUNTY | DISTRICT | SCHOOL SITE | PLACEMENTS / PROGRAMS | | LENGTH IN PROGRAM | | |
| | | | | | | | |
| | | | | | | | |
| GRADES REPEATED | SCHOOL ATTENDANCE: (Circle) GOOD <i>FAIR</i> <i>POOR</i> (Explain "Fair" to "Poor" ratings) | | | | | | |
| YOUR EDUCATIONAL CONCERN(S) ABOUT THIS CHILD IS? | | | | | | | |
| WHAT DO YOU ENJOY THE MOST ABOUT THIS CHILD? | | | | | | | |
| FAMILY HISTORY | | STUDENT IS: (1st Born, etc.) | | NUMBER OF BROTHERS? | NUMBER OF SISTERS? | NUMBER OF PREGNANCIES & MISCARRIAGES: | |
| FATHER'S AND MOTHER'S GENERAL HEALTH? | | | | | | | |
| SIBLINGS: Name | | BIRTHDATE | | HEALTH | | | |
| | | | | | | | |
| | | | | | | | |
| LEARNING PROBLEMS / SPECIAL EDUCATION HX: Parents, Siblings, and Other Family Members | | | | | | | |
| STUDENT'S HISTORY | | MOTHER'S AGE / HEALTH / MEDICATION / SUBSTANCE AND TOBACCO USE DURING THIS PREGNANCY: | | | | | |
| BIRTH TERM | BIRTH WEIGHT | | | | | | |
| LABOR / DELIVERY: <input type="checkbox"/> Anesthesia <input type="checkbox"/> Cesarean <input type="checkbox"/> Prolonged Labor <input type="checkbox"/> Mal-Presentation, etc. (Check and explain) | | | | | | | |
| BIRTH HISTORY: <input type="checkbox"/> Cry <input type="checkbox"/> Color <input type="checkbox"/> Respiration <input type="checkbox"/> Injection <input type="checkbox"/> Transfusion <input type="checkbox"/> Incubation <input type="checkbox"/> Jaundice <input type="checkbox"/> Resuscitation <input type="checkbox"/> Post Maturity <input type="checkbox"/> Prematurity <input type="checkbox"/> Anomalies <input type="checkbox"/> Other (Check and explain) | | | | | | | |
| DIFFERENT THAN OTHER BABIES: Explain | | | | | | | |

NAME: _____ BIRTHDATE: _____

Prefer section be completed by a credentialed school nurse or include comprehensive health history from student's physician.

| DEVELOPMENTAL HISTORY | | | | Enter Age; or check () if unusual or explain | | | | | |
|--|--------------------|------------------------------|--------------|---|-----------|-----------------|------------------|--------------|-----------------|
| CRAWLED: | SAT: | WALKED: | FIRST WORDS: | PHRASES: | FED SELF: | TOILET-TRAINED: | BLADDER-TRAINED: | DENTAL: | COORDINATION: |
| GETTING ALONG: | UNUSUAL ATTITUDES: | DESTRUCTIVE/UNUSUAL BEHAVIOR | | AGGRESSIVE BEHAVIOR: | | EXTREME FEARS: | WITHDRAWN: | HYPERACTIVE: | HAND-DOMINANCE: |
| OTHER: | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| COMPARED TO OTHER CHILDREN, THIS CHILD IS: | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

| HEALTH SCREENING / PROGRAMS / AGENCIES | | | | NAME OF PRIMARY DOCTOR: | | | | | |
|---|--|----------|---------|-------------------------|--|-------|--|--|--|
| VISION TEST DATE: | | RESULTS: | | | | | | | |
| HEARING TEST DATE: | | RESULTS: | | | | | | | |
| HEIGHT: | | | WEIGHT: | | | HEAD: | | | |
| IMMUNIZATIONS: <i>(Include a copy)</i> | | | | | | | | | |
| IF THERE IS A PROBLEM, CHECK THE KEY WORD(S) AND ENTER NUMBER(S), DATE(S), DIAGNOSIS, RECOMMENDATIONS, AND THE MEDICAL DOCTOR(S) OR AGENCY(IES) CARE: | | | | | | | | | |
| <input type="checkbox"/> (1) EENT <input type="checkbox"/> (2) Orthopedic <input type="checkbox"/> (3) G.U. <input type="checkbox"/> (5) Respiratory <input type="checkbox"/> (6) Circulatory <input type="checkbox"/> (7) Endocrine <input type="checkbox"/> (8) Connective Tissue <input type="checkbox"/> (9) Neuromuscular <input type="checkbox"/> (10) Genetic/Chromosome Problems <input type="checkbox"/> (11) Skin <input type="checkbox"/> (12) Nutrition <input type="checkbox"/> (13) Poisoning <input type="checkbox"/> (14) Allergies <input type="checkbox"/> (15) Convulsions <input type="checkbox"/> (16) Chronic Recurring Conditions <input type="checkbox"/> (17) Serious Illness <input type="checkbox"/> (18) Injuries <input type="checkbox"/> (19) Medication(s) <input type="checkbox"/> (20) Operation(s) <input type="checkbox"/> (21) Hospitalization(s) <input type="checkbox"/> (22) Equipment, Hardware, Other Aids <input type="checkbox"/> (23) Special Needs <input type="checkbox"/> (24) OTHER: _____ | | | | | | | | | |
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|--|--|--|--|---|--|--|--|--|--|
| HISTORY INFORMATION RELIABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | REASON: <input type="checkbox"/> Foster Care <input type="checkbox"/> Child not with Parents <input type="checkbox"/> Other | | | | | |
| DO YOU FEEL AS THOUGH THIS CHILD'S HEALTH IS: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Fair <input type="checkbox"/> Poor <i>(check one)</i> | | | | | | | | | |

| HOME-FAMILY RELATIONSHIP | | | DESCRIBE PHYSICAL AND EMOTIONAL CLIMATE OF HOME, INCLUDING NURTURING, ACCEPTANCE, THE PHYSICAL PLANT, WHO LIVES IN HOME, ETC. | | | | | | |
|--------------------------|--|--|---|--|--|--|--|--|--|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

INTERVIEWEE'S NAME AND RELATIONSHIP TO STUDENT _____
 INTERPRETER USED: _____ LANGUAGE USED: _____
 YES NO

PERSON INTERVIEWING _____
 DATE / POSITION: _____

FCOE Special Education Program Referral Application for: _____ [Student]

_____ [Date of Birth]

Current Educational Performance and Assessments
Documented Program Information/Modifications

History of Educational/Agency Services

| Date | Age/Grade | School | Services |
|------|-----------|--------|----------|
| | | | |
| | | | |
| | | | |
| | | | |

Agency Services (Attach reports from all agencies identified)

- Regional Center California Children’s Services (CCS) Dept. of Social Services (DSS)
 County Mental Health (CMH) Department of Rehabilitation (DR)
 Specify any additional agency _____

Description of Educational Setting

Current School Program _____

Is the student ambulatory? Yes ___ No ___ If no, list equipment/supports _____

DIS/Support Services _____

Special Factors

Is the student an English Learner? Yes ___ No ___ If yes, provide CELDT or ALPI Level _____

Does the student have special transportation needs? Yes ___ No ___ If yes, describe _____

Does student require assistive technology devices and/or services? Yes ___ No ___ If yes, describe _____

Does student require low incidence services, equipment, and/or materials to meet educational needs?
Yes ___ No ___ If yes, describe _____

Does the student’s behavior impede his/her learning, or the learning of others? Yes ___ No ___ If yes, describe _____

Behavior Support Plan (BSP) attached _____ Behavior Intervention Plan (BIP) attached _____

FCOE Special Education Program Referral Application for: _____ [Student]

_____ [Date of Birth]

Summary of Student's Current Academic Achievement and Functional Performance

| |
|--|
| Strengths/Interests/Learning Preferences: |
| Cognitive Abilities: Pre-Academic/Academic Skills: |
| Communication Skills: |
| Motor Skills: |
| Social/Emotional/Behavioral: |
| Health: |
| Self-Help/Daily Living Skills: |
| Community/Leisure Skills/Preferred Activities: |
| Pre-vocational/Vocational Skills: |
| Curriculum Accommodations/Modifications: |
| Participation in State/District Assessments: STAR: CST ___ CAT/6 ___ CMA ___ CAPA ___ Level 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> DRDP (Desired Results Developmental Profile/Preschool) ___ CELDT ___ ALPI ___ PFT ___ Other assessments _____ |