

## **Referral to the FCOE Adult Transition Program: Procedural Guidelines**

- By October 1<sup>st</sup>** Request for FCOE ATP Placement Consideration and Referral Application for the Adult Transition Program shall be completed for each student to be referred to the FCOE Adult Transition Program for enrollment for the next school year. The *Request for ATP Placement Consideration* shall be completed by the district's Special Education Department representative or the student's case manager and sent or faxed to the FCOE Director of Special Education in September of the current school year. The *Referral Application for the Adult Transition Program* shall be completed to provide the most current student information and sent or faxed to the FCOE SD/Transition Consultant.
- October-December** Under the direction of the SD Consultant, the FCOE Transition Team will make a visitation to the district high school classroom to meet with the student and teacher. The observation process will include a review of student files to evaluate eligibility for the FCOE Adult Transition Program. Information about the FCOE Adult Transition Program will be provided to the district teacher for dissemination to each student and his/her parent(s). Once eligibility is confirmed, the SD Consultant will work with the district to develop transition activities appropriate for each student.
- October-April** In special circumstances, a district representative may contact the FCOE SD Consultant and request that a representative from FCOE attend selected IEP meetings when additional information and/or support might be needed.
- October-April** At district transition IEP meetings, "Refer to FCOE Adult Transition Program" is written on the IEP for any student who meets the eligibility for referral. In addition, it should be noted that the student will continue to receive Special Education services from FCOE and therefore is not exiting from Special Education. The student, district representative and parent/care provider should sign the Letter of Intent to Enroll indicating informed consent for the student to enroll in the FCOE Adult Transition Program.
- By April 1st** Completed FCOE ATP Transition Packets and Letters of Intent to Enroll are forwarded for review to the FCOE SD Consultant.

**March/April**

After reviewing the referrals and transition packets, selected individual student staffings may be held if necessary.

**By June 1<sup>st</sup>**

District teachers send school-based files to the district's Special Education Department. Files for students enrolled in district Extended School Year Programs should be forwarded to the district Special Education Department by the last day of the Extended School Year session.

**By July 1<sup>st</sup>**

All confidential, school-based and health files are delivered by the district to the Pupil Personnel Department, Fresno County Office of Education, 1111 Van Ness Ave., Fresno, CA 93721.

Fresno County Office of Education  
Special Education Department  
1111 Van Ness Ave., Towers 8  
Fresno, CA 93721  
Fax: (559) 265-3076

**Request for**  
**FCOE ATP PLACEMENT CONSIDERATION**

Refer to the Referral to the FCOE Adult Transition Program: Procedural Guidelines for information regarding the referral process and timelines. Please complete all information and send to:

**Pat Sims**  
**Director, Special Education**  
**Fresno County Office of Education**  
**1111 Van Ness, Towers 8<sup>th</sup> Floor**  
**Fresno, CA 93721**  
**Ph: 265-3051 fax: 265-3076**  
**psims@fcoe.org**

Student's Name \_\_\_\_\_

Student's ID Number \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring District of Residence \_\_\_\_\_

School \_\_\_\_\_

Current Placement \_\_\_\_\_

Teacher \_\_\_\_\_

Classroom Number \_\_\_\_\_ Contact Phone \_\_\_\_\_

Contact e-mail address \_\_\_\_\_

Referred by \_\_\_\_\_

Title \_\_\_\_\_ phone \_\_\_\_\_

e-mail address \_\_\_\_\_ fax \_\_\_\_\_

***In order to expedite the referral process and to allow the FCOE Transition Team adequate time to evaluate each referral, please submit requests by October 1<sup>st</sup> for consideration for the following school year.***

### Referral Application to the FCOE Adult Transition Program

Teacher of Record \_\_\_\_\_ Phone \_\_\_\_\_

Regional Instructional Specialist \_\_\_\_\_ Phone \_\_\_\_\_

School Site & Room Number \_\_\_\_\_

- |  |  |
|--|--|
| <input type="checkbox"/> Center-based/Self-contained classroom setting     | <input type="checkbox"/> Deaf and Hard of Hearing /SDC |
| <input type="checkbox"/> Functional Skills/SDC on General Education campus | <input type="checkbox"/> Full/Partial Inclusion        |
| <input type="checkbox"/> Orthopedically Impaired/SDC                       | <input type="checkbox"/> Other _____                   |

#### Student Information

Name \_\_\_\_\_ Gender: M F

Birth Date \_\_\_\_\_ Student ID Number \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Language \_\_\_\_\_ Student:  EL  FEP  EO

#### Education/Transition Support

District of Residence \_\_\_\_\_ District of Service \_\_\_\_\_

Disabling Condition (s) as identified on IEP \_\_\_\_\_

Date of last IEP \_\_\_\_\_ Date of last Reevaluation \_\_\_\_\_

#### Mode of Transportation:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> First Student   | <input type="checkbox"/> District Transportation | <input type="checkbox"/> Requires Wheelchair transportation |
| <input type="checkbox"/> Requires safety harness   | <input type="checkbox"/> Private Driver          | <input type="checkbox"/> Parent Transports                  |
| <input type="checkbox"/> Student mobility trained: <input type="checkbox"/> Walks <input type="checkbox"/> Rides a bike <input type="checkbox"/> Uses FAX/City Transit <input type="checkbox"/> Uses HandiRide |  |   |

#### School-Based Services

- |   |   |   |                                       |   |
|---|---|---|---------------------------------------|---|
| <input type="checkbox"/> Speech           | <input type="checkbox"/> Adaptive PE          | <input type="checkbox"/> School Psychologist                    | <input type="checkbox"/> School Nurse | <input type="checkbox"/> Physical Therapy     |
| <input type="checkbox"/> DHH              | <input type="checkbox"/> VI                   | <input type="checkbox"/> Orientation and Mobility               | <input type="checkbox"/> OI           | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Sign Interpreter | <input type="checkbox"/> Assistive Technology | <input type="checkbox"/> Extended School Year: Yes ____ No ____ |                                       |   |
| <input type="checkbox"/> Other _____      |   |   |                                       |   |

Supplemental Aids and Services (List): \_\_\_\_\_

Assistive technology/Communication devices used: \_\_\_\_\_

Specialized Equipment (List Low Incidence items): \_\_\_\_\_

#### Types of Instruction Received

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Functional Academics  | <input type="checkbox"/> Home/Personal Management    | <input type="checkbox"/> Vocational skills         | <input type="checkbox"/> Communication skills |
| <input type="checkbox"/> Behavior/Social skills  | <input type="checkbox"/> Community based Instruction | <input type="checkbox"/> Special Olympics Training |   |
| <input type="checkbox"/> Medical support Plan Provided <input type="checkbox"/> Positive Behavior Support Plan Provided <input type="checkbox"/> Other _____ |  |  |   |

**Student** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Summary of Student's Current Functional Performance**      **Date of Summary** \_\_\_\_\_

<u>Strengths/Interests/Learning Preferences</u>
<u>Communication Skills</u>
<u>Motor Skills/Fine and Gross Motor</u>
<u>Health</u>
<u>Social/Emotional/Behavioral</u>
<u>Self Help/Adaptive</u>
<u>Pre-Vocational/Vocational</u>
<u>Additional Comments</u>

**Student** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Current Service Providers**

Agency Service Providers	Agency contact person and phone number
Central Valley Regional Center (CVRC)	
California Children’s Services (CCS)	
Department of Rehabilitation (DR)	
County Mental Health (CMH)	
Department of Social Services (DSS)	
Probation	
Other	

**Transition Plan**

Date of Transition Plan: \_\_\_\_\_

Summary of Post-school outcomes

- Instruction/Functional Skills (communication/functional academics etc )
  
- Community/ Leisure/Recreation
  
- Employment
  
- Domestic/Daily Living

Projected needs/ barriers/recommendations

Prior to scheduled meeting with FCOE for consideration of placement in the Adult Transition Program:

- Complete *Request for ATP Placement Consideration* and send to the Director, Department of Special Education, Moderate/Severe Programs, Fresno County Office of Education, Towers 8<sup>th</sup> Floor, Fresno, CA, 93721 or fax to (559) 265-3076. Submit *Referral Application* to the SD/Transition Consultant, Department of Special Education, Moderate/Severe Programs, Fresno County Office of Education, Towers 6<sup>th</sup> Floor, Fresno, CA, 93721, or fax to (559) 265-4059.
- Obtain Release of Information from family

At the time of scheduled meeting, provide:

- Student file for review
- Copy of current IEP/Transition plan documents
- Copy of most current assessment information (psychologist, speech/language pathologist, other DIS support)
- Copy of a current Health Summary