



# Special Education Programs Referral Form

Student Services  
**Trina Frazier**  
Assistant Superintendent

\*Please read instructions carefully to help prevent a delay in processing your application\*

Identifying Information				
Student Name:		Date of Birth:		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary
District of Residence:		Grade:	SSID:	Interdistrict Transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No
Student Address:			City:	Zip Code:
Student Lives With: <input type="checkbox"/> Parent/Guardian(s) <input type="checkbox"/> Foster <input type="checkbox"/> Homeless <input type="checkbox"/> Short-Term Residential Therapeutic Program/ Group Home (STRTP)				
Name of Parent/Guardian or Ed Rights Holder:			Phone:	Email:

Type of Referral				
<p><b>Initial referral:</b> Please check the program you are referring the student to, and all the boxes that apply below the program heading.  <a href="#">Click here for link to Special Education Program criteria</a></p> <p><b>Interim referral:</b> If referral is an interim, please check the interim box. (when submitting application, type "Interim" in email subject heading)  <a href="#">Click here for link to Interim Placement flow chart and required documentation</a></p>				

PIP (Preschool Autism) <input type="checkbox"/> Initial <input type="checkbox"/> Interim	CIRCLE (Elementary Autism) <input type="checkbox"/> Initial <input type="checkbox"/> Interim	TIES (ED) <input type="checkbox"/> Initial <input type="checkbox"/> Interim	ESN <input type="checkbox"/> Initial <input type="checkbox"/> Interim	DHH <input type="checkbox"/> Initial <input type="checkbox"/> Interim
<input type="checkbox"/> 3-5 years old <input type="checkbox"/> Primary Autism <input type="checkbox"/> Language deficits <input type="checkbox"/> Social deficits <input type="checkbox"/> Behavioral needs <input type="checkbox"/> Not I.D. <input type="checkbox"/> Assessment within 6 months	<input type="checkbox"/> TK-6th grade <input type="checkbox"/> Primary Autism <input type="checkbox"/> Language deficits <input type="checkbox"/> Speech service & goal <input type="checkbox"/> Social deficits <input type="checkbox"/> Related goal <input type="checkbox"/> Behavior deficits <input type="checkbox"/> Related goal &/or BIP/DTP <input type="checkbox"/> SAI or other services that address social and behavior deficits <input type="checkbox"/> District LRE continuum exhausted prior to referral <input type="checkbox"/> Not I.D. or Fragile X <input type="checkbox"/> Assessment within 1 year	<input type="checkbox"/> Primary ED <input type="checkbox"/> Behavior deficits <input type="checkbox"/> Current BIP or DTP <input type="checkbox"/> SAI or other services that address social and behavior deficits <input type="checkbox"/> Placement requires an SDC setting at least 50% of the day <input type="checkbox"/> District LRE continuum exhausted prior to referral <input type="checkbox"/> Not I.D. <input type="checkbox"/> Not Primary Autism or TBI <input type="checkbox"/> Assessment within 1 year	<input type="checkbox"/> Primary or Secondary I.D. In general: <input type="checkbox"/> Cognitive <55 <input type="checkbox"/> Adaptive <55 <input type="checkbox"/> Academic <55 <input type="checkbox"/> TK- adult- Assessment within the past 2 years <input type="checkbox"/> Preschool- Assessment within 6-12 months	<input type="checkbox"/> Bilateral hearing loss with at least a moderate loss in the better ear <input type="checkbox"/> Communicates with, or is learning to communicate through ASL <input type="checkbox"/> DHH Oral Preschool- Wears hearing devices all day <input type="checkbox"/> Assessment within 1 year

LRE/Classroom Supports	Please note additional LRE placement/support options previously provided to student:
<input type="checkbox"/> General Education <input type="checkbox"/> General Education Small Group Instruction <input type="checkbox"/> Specialized Academic Instruction (SAI/RSP) <input type="checkbox"/> Special Day Class (SDC) <input type="checkbox"/> Additional Classroom Support Staff <input type="checkbox"/> Sp. Ed. <input type="checkbox"/> Gen. Ed.	<input type="checkbox"/> Related Services: _____ <input type="checkbox"/> Behavior Intervention Plan/ Direct Treatment Protocol (BIP/DTP) <input type="checkbox"/> Functional Behavior Assessment (FBA) <input type="checkbox"/> SELPA Supports (Autism Consultation) <input type="checkbox"/> 1:1 Classroom Assistant <input type="checkbox"/> Other: _____ <input type="checkbox"/> 1:1 LVN/Health Aide <input type="checkbox"/> Car Seat <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bus Assistant <input type="checkbox"/> Safety Vest

Documentation		
<input type="checkbox"/> Parent Authorization Form (Not required for Interim referral) <input type="checkbox"/> Cover Letter: Statement of why referral to the FCSS Special Education Program has been determined appropriate. <input type="checkbox"/> Current IEP- including progress reports, notes, BIP/DTP (if applicable) and signature page with signatures.		
<input type="checkbox"/> Language Information <input type="checkbox"/> Home Language Survey <input type="checkbox"/> Birth Certificate	<input type="checkbox"/> Current Health Information <input type="checkbox"/> Health Report- Including vision & hearing screening <input type="checkbox"/> Immunization Record/Waiver <input type="checkbox"/> Health Plan (if appropriate) <input type="checkbox"/> Audiological Evaluation (for DHH referrals) <input type="checkbox"/> Medical Reports (as appropriate)	<input type="checkbox"/> Multidisciplinary or individual reports including <input type="checkbox"/> Psychological Report <input type="checkbox"/> Academic Report <input type="checkbox"/> Speech and Language report <input type="checkbox"/> Other (OT, APE, DHH, VI, OI, O&M, etc.) <input type="checkbox"/> Consultation notes/reports from SELPA (Autism Team)

### District Authorization

District Contact Information * This is the person we will be contacting for questions about the referral			
Referring Person:		Title:	
Email address:		Contact Number:	Date of referral:

District/LEA Representative/Administrative Designee:	
<input type="checkbox"/> This student is an interim, <b>OR</b> the full continuum of placement options has been exhausted by the district.	
Signature:	Print Name:
Title:	Date:



## Fresno County Superintendent of Schools Special Education Services - Parental Authorization

Dear Parents/Guardians:

Your child is being referred to a special education program operated by the Fresno County Superintendent of Schools (FCSS) Special Education Department. Prior to your child being considered for placement in an FCSS program, you must sign and date this form, which will become part of the referral packet.

*Special Education Programs for Consideration (check one):*

- PIP** - Autism Preschool Intervention Program     **ESN** - Moderate/Severe Disabilities  
 **CIRCLE** - Autism Program     **DHH** - Deaf and Hard of Hearing Program  
 **TIES** - Targeted Intervention for Emotional Support Program

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

- You will be invited to be present at the Individualized Education Program (IEP) team to discuss placement consideration; and
- You will be contacted in advance of the IEP team meeting date, and notified of the time and place of the IEP team meeting; and
- Your child will not be placed in an FCSS program without your written consent; and
- If home-to-school transportation is required, it will be arranged by your child's school district.

**We, the undersigned parents or guardians, hereby request that the Fresno County Superintendent of Schools, give consideration to the placement of our child,**

\_\_\_\_\_  
*Student Name*

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

**in a special education program operated by the Fresno County Superintendent of Schools in accordance with provisions of the California State Education Code. We give the Fresno County Superintendent of Schools special education staff permission to observe my child in his/her educational setting and/or include interviewing the student, interviewing staff, reviewing records and the like.**

\_\_\_\_\_  
***Signature of Parents/Guardians***

\_\_\_\_\_  
***Date***

\_\_\_\_\_  
**Print Name**