PROCEDURES FOR HOLDING MEETING FOR TEMPORARY PLACEMENT OF TRANSFER STUDENTS WHO RECEIVE SPECIAL EDUCATION SERVICES

FORMS REQUIRED FOR COMPLETION:

1) **Notice of Procedural Safeguards and Receipt** – Campus personnel complete information – obtains parent signature and provides them with copy of Procedural Safeguards

2) **Temporary Placement of a Transfer Student Who Receives Special Education Services form**– If special education records are not presented by parents or otherwise available, CALL THE PREVIOUS SCHOOL'S SPECIAL EDUCATION DEPARTMENT to obtain information PRIOR TO OR DURING the Temporary Placement meeting. All team members involved MUST sign the signature page. PARENT AND ADMINISTRATOR SIGNATURES ARE REQUIRED. Remember to send a copy of the accommodations page to all general education teachers and special education teachers.

3) **Notice of Release/Consent to Request Confidential Information** – Make sure parent signs form or we will not be able to obtain records.

   WITHIN TEXAS: Request special education records through TREx according to your campus procedures.

   OUT OF STATE: Obtain adequate mailing address for special education department of previous school and FAX RELEASE TO THE PREVIOUS SCHOOL DISTRICT. Records are to be mailed to Gregg County SSA and copies will be forwarded to the appropriate campus. There are federal and state regulations regarding timely release of records.

4) Parent Consent for Temporary Placement following Transfer of Student Receiving Special Education Services MUST be signed by parent.

5) **STAAR information** (Call the sending district for past determinations.)
6) **Copy of Home Language Survey**
7) **Copy of Birth Certificate**
8) **Copy of Social Security Card**

ADD THE FOLLOWING FORMS FOR SPECIFIC INSTANCES:

IF THE STUDENT IS MEDICAID-ELIGIBLE:

9) **Parent Notification to Release Information for School based Medicaid Services in Texas**
10) **Parent Consent to Release Information for School based Medicaid Services and for district to access Medicaid benefits**

IF THE STUDENT REQUIRES SPECIAL TRANSPORTATION:

11) **Special Transportation Information**

IF THE STUDENT IS AGE 15 OR OLDER:

12) **Transition Consent Release**

THEN:

Assign one campus staff member to be responsible for notifying by phone (903/984-4416; 903/981-0591) of the enrollment of the new student. A copy of the Transfer IEP/ARD Form may be placed in the new student's special education campus file. The entire Transfer IEP/ARD packet is to be forwarded by email to dpoteet@sabineisd.org or fax to 903/986-3408 **IMMEDIATELY.**

_____ _____

Principal Date

TEMPORARY PLACEMENT OF A TRANSFER STUDENT WHO RECEIVES SPECIAL EDUCATION SERVICES

_____ ISD

FIRST DAY STUDENT IS ATTENDING SCHOOL _____

DATE OF TEMPORARY PLACEMENT MEETING _____

Student SS#: _____ Student ID: _____

Student's Name: _____ *(first, middle, last)*

Student's Address: _____ *(Street/PO Box, City, State, Zip)*

Is Student in: ☐ Foster Care ☐ Residential Care ☐ Group Home

Student Resides with _____ *(Parent, Foster Parent, Facility, Group Home names, etc.)* DOB: _____

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino Sex: ☐Male ☐Female Age: _____ Grade: _____

Race: ☐AI/AN ☐Asian ☐B/AA ☐NHPI ☐White Primary Language: _____ *(English, Spanish, etc.)*

Father's Name: _____ Father's Address: _____
(Street/PO Box, City, State, Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Mother's Name: _____ Mother's Address: _____
(Street/PO Box, City, State, Zip)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

An interpreter was used to assist in conducting this meeting. ☐ Yes ☐ No
If yes, specify language or mode of communication: _____

☐ The parent(s) verify that the student was receiving special education services at _____ ISD.

Former ISD Address: _____ Former ISD Phone #: _____
(Street/PO Box, City, State, Zip)

Student's eligibility was verified by: _____ Date verified: _____

Staff member contacted at former school: _____ Title: _____

Eligibility Type: _____ Date of Last ARD: _____ Date of Last Evaluation: _____

Special Education Service Provided: Related Services Provided:

STAAR TEST DETERMINATIONS:

☐ The ARD Committee has appropriate evaluation data and other information to develop and implement a complete IEP. If the above box is checked, do a transfer ARD immediately.

Or

☐ Eligibility is temporary contingent upon receipt of valid assessment/evaluation date or collection of new assessment/evaluation data. Interim special education services and placement will be determined. A second ARD Committee meeting will be held within 30 school days to develop an IEP based on assessment/evaluation data available at that time.

Deliberations:

Staff member completing this form: _____

_____ **ISD**

COPY FOR SPED TEACHER AND ALL GEN ED TEACHERS WHO TEACH CLASSES WITH ACCOMMODATIONS

Student: _____ **Temporary Placement Meeting Date:** _____

Determination of services to be provided:

Subject	Qtr/ Sem	Grade Assigned	Gen Ed Min Freq/Period (time(s)/day)	Sp Ed Min Freq/Period (time(s)/day)	Service Type 0 – Direct 1 – Consult/Indirect 2 – In Class Support 3 – Co-Teaching	Class Accommodations

Min. Gen. is provided in the general education classroom. Min. SpEd and/or Min. Related Service are provided outside the general education classroom. Special locations for providing services are described as part of the subject in the Related Service Other Column, or in the deliberations.

Related Service*	Provider	Service Type	Min	Freq/Period (time(s)/day)	Other	Qtr/ Sem

*Because OT and PT require a prescription from a physician, OT and PT services will not be immediately initiated until prescription is obtained. Generally, the student will receive a consult visit during the first 30 school days by the OT/PT. Students who receive speech therapy as a secondary service will also receive a consult visit. If Speech therapy is the only service a student receives, services will start immediately. (Make sure parent is aware of this.) Student's physician who provides prescription for OT and PT: _____

Determination of Placement:

Current Campus: _____ Instructional Arrangement: _____ (SPED Office will complete.)

☐ Yes ☐ No This is the campus which the student would attend if not in special education.
If no, name the student's home campus: _____

☐ Yes ☐ No This is the campus that is as close as possible to the student's home which provides the services the temporary placement has deemed necessary.

Dates services are to begin: _____

Anticipated duration of services for temporary placement: maximum of 30 school days

_____ ISD

STATE ASSESSMENT DETERMINATIONS FOR CURRENT SCHOOL YEAR

Grade: _____ ☐ Spanish, if available

	Math	Writing	Reading	Science	Social Studies
Previous CSR/Met					
Assessment	Gen Acc Alt	Gen Acc Alt	Gen Acc Alt	Gen Acc Alt	Gen Acc Alt
Accommodations					

Other Assessments

	Accommodations
For Limited English Proficient Students only (TELPAS) ☐ Will Take: ☐Listening ☐ Speaking ☐ Writing ☐ Will Not Take: ☐N/A ☐ Instructional Level: Click here to enter text.	
Early Reading Assessment (TPRI, Tejas LEE, etc.) K-2 ☐ Will Take ☐ Will Not Take ☐ N/A	
Other District Assessments: ☐ Will Take All ☐ N/A ☐ Will Take the Following:	

SIGNATURES OF TRANSFER MEETING MEMBERS

Signatures	Position	Ag	Dag
	Parent/Adult Student	☐	☐
	Administration	☐	☐
	Instruction	☐	☐
	Special Education	☐	☐
	Assessment	☐	☐
	Student	☐	☐
	GTE Teacher	☐	☐
		☐	☐
		☐	☐

Ag = Agree
Dag = Disagree

Parent/Adult Student Participation Mode
_____ In Person
_____ By Phone
_____ Other

☐ YES ☐ NO ☐ NA I/We have been informed in my/our native language about the School Health & Related Services (SHARS) program. I/We give my/our consent for the school district to access this student's Medicaid benefits for services described in this ARD now or if he/she becomes eligible prior to this consent. I/We understand that if I/we do not provide consent, the district must provide IEP related services. I/we understand that I/we can revoke future consent at any time. I/we understand that giving permission will not affect this student's future benefits. I/we consent to the release of information necessary for the district to receive said Medicaid benefits.

☐ This transfer placement has been developed by mutual agreement.

COMPLETE ONLY IF STUDENT REQUIRES SPECIAL TRANSPORTATION

SPECIAL TRANSPORTATION INFORMATION

Reason ☐ Start Service ☐ Continue Service ☐ Change Pick-up/Drop-Off ☐ Change student info
☐ Discontinue Service ☐ Other _____ Date Services to Begin: _____

School Name: _____ **Student ID:** _____

Home Campus: _____ **Grade:** _____

Student's Name: _____ **DOB:** _____

Parent's Name: _____ **Emergency Contact #:** _____

Home Address: _____ **Home Phone:** _____
(Street/PO Box, City, State, Zip)

Work Phone: _____ **Cell Phone:** _____

Background

☐ Ambulatory ☐ Diabetic ☐ Non-Ambulatory ☐ Verbal ☐ Non-Verbal
☐ Autism ☐ Hearing Impairment ☐ Other Health Impaired/Medically Fragile
☐ Behavioral Concerns ☐ Communication Disorder ☐ Seizure Disorder ☐ Visual Impairment
☐ Cognitive Disability ☐ Hemophiliac ☐ Other ☐ Wheelchair

Competencies (indicate those relevant to successfully transporting this student:

☐ can identify bus # ☐ can sit independently ☐ cam visually locate exits
☐ can walk independently ☐ can fasten seat belt ☐ can recognize strangers
☐ can ascend stairs ☐ can follow oral instructions ☐ can tolerate extended bus rides
☐ can descend stairs ☐ can express needs ☐ can follow oral instructions with
☐ can locate seat ☐ can use sign language speech/reading and gestures
☐ Other: _____

Special Needs: ☐ Needs bus aide or bus monitor Medical/Medication: _____
Special Equipment/other information: _____

☐ Regular Year ☐ ESY ☐ Program: _____

BEFORE SCHOOL PICK-UP

From: _____ To: _____
Class Start Time: _____

SHUTTLE A ☐ Yes ☐ No Pick-up Time: _____ To: _____
Start Time: _____

SHUTTLE B ☐ Yes ☐ No Pick-up Time: _____ To: _____
Start Time: _____

AFTER SCHOOL DROP-OFF

To: _____ End Time: _____

Student's home attendance zone: ☐ Yes ☐ No

☐ Yes ☐ No I grant permission for my child to be left without supervision by the transportation department. IF no, an adult must be present to receive the child at the above address or the following alternate address within the school district: (Name, address, phone)

_____

Parent/Adult Student Signature **Campus/Admin Signature**

Consent for Temporary Placement following Transfer of Student Receiving Special Education Services

Check all that apply:

☐ Yes ☐ No I have been fully informed and understand the temporary placement that has been determined for my student.

☐ Yes ☐ No I understand and agree with the temporary placement decision and give my permission for the services that have been proposed for my child/me.

☐ Yes ☐ No I understand that my consent for services is voluntary and may be revoked at any time. However, if I revoke consent after services begin, my/child's services will not change unless:

a) the school and I agree otherwise (following ARD Committee procedures), or
b) a due process hearing resolves the dispute

Your rights were explained to you when your child was initially referred for special education assessment. Federal regulations require that parents and adult students be provided a full explanation of all procedural safeguards in your native language or other mode of communication each time the district proposes or refuses to initiate or change the identification, evaluation or educational placement of your child or the provision of a free appropriate public education (FAPE) to your child. A full explanation of all procedural safeguards is included with this form. Please contact Vicki Thornton at 903/984-4416 or 903/981-0591 if you have any questions or need names of other individuals to assist you in understanding this document or your procedural safeguards.

_____ _____

Signature of Parent, Guardian,
Surrogate Parent or Adult Student

_____ _____

Signature of Interpreter (if used)

☐ Release Information
☐ Request Information

GREGG COUNTY SPECIAL EDUCATION
SHARED SERVICE ARRANGEMENT

*Date Sent/Mailed: _____

NOTICE FOR RELEASE / CONSENT TO REQUEST CONFIDENTIAL INFORMATION

PLEASE RETURN A COPY OF THIS FORM WITH THE STUDENT'S RECORDS

Student: _____ **DOB:** _____

We are asking that you authorize the person or agency named below to release/to request specified records containing confidential information regarding the above-named student to the following staff person.

***PERSON/AGENCY REQUEST FROM / RELEASED TO:**

Gregg County Special Education SSA
ATTN: Records Clerk
5303 Old Hwy 135 North
Gladewater, TX 75647
(903)984-4416; (903)981-0591 FAX: (903)986-3408

*RECORDS TO BE RELEASED/RECORDS REQUESTED			*PURPOSE OF DISCLOSURE
☐ Full and Individual Evaluation	☐ Birth Cert/Guardianship/Conservatorship Papers		☐ Educational Placement
☐ IEP Team Meeting	☐ Medical Records		☐ Educational Programming
☐ Parent Approval of Service	☐ Immunization Record		☐ Other _____
☐ OT/PT/APE Evaluation	☐ Speech Assessment		☐ Other _____
☐ Vision/Hearing Exams or Screening	☐ Individual Transition Plans		
☐ Vocational Assessment	☐ Eligibility Reports	☐ Family Records	
☐ Psychological Report	☐ Other : _____		

Please check ☒ the appropriate boxes below. For more information please call:

_____ Director of Special Education _____ at: (903)981-0591

☐ YES ☐ NO *I have been fully informed and understand the school's request for my consent, as described above. This information will be released/requested upon receipt of my written consent.

☐ YES ☐ NO *I understand that my consent is voluntary and may be revoked anytime.

☐ YES ☐ NO *I understand that I will be notified in writing of each release of educationally related information.[1]

*Your rights were explained to you when you were/your child was initially referred for special education evaluation. Federal regulations require that parents and adult students be provided a full explanation of all procedural safeguards (rights) in their native language or other mode of communication each time the district proposes or refuses to initiate or change the identification, evaluation, or educational placement of you or your child or the provision of a free appropriate public education (FAPE) to you or your child.

If you want more information or if you have any questions, please call the principal at the school number or call the Director of Special Education at (903)984-4416 or (903)981-0591. Other state and local agencies familiar with IDEA requirements include: ARC of Texas (association for Retarded Citizens at (512)454-6694, Gregg County Association for Retarded Citizens at (903)753-1723, Advocacy, Inc. at (800)252-9108 and PATH (People Attempting to Help) at (903)983-8694.

_____ _____
*SIGNATURE OF PARENT, GUARDIAN, SURROGATE PARENT OR ADULT STUDENT *DATE

(NEW) ADDRESS _____

_____ _____
*SIGNATURE OF INTERPRETER, IF USED *DATE

Please return this form to: _____ at: _____ as soon as possible.
SCHOOL STAFF PERSON

[1]Required only when a school district does not include in its policy a notice that education records are forwarded to other agencies or institutions that have requested the records and in which the student seeks or intends to enroll.

*Denotes required items

7/2012

GREGG COUNTY SPECIAL EDUCATION SHARED SERVICE ARRANGEMENT

RECEIPT OF

NOTICE OF PROCEDURAL SAFEGUARDS

(Revised July 2018)

NAME OF STUDENT: _____ **DATE OF BIRTH:** _____

District: _____ **Campus:** _____ **Grade:** _____

DATE PROVIDED: _____

METHOD:

- ☐ US Postal Service
- ☐ Delivered in person by _____
- ☐ Sent home with student
- ☐ Other Method: _____

DOCUMENTS PROVIDED IN ☐ English ☐ Spanish ☐ Other Method: _____

This is to verify that I have received a copy of ***Notice of Procedural Safeguards: Rights of Parents of Students with Disabilities*** (revised July 2018), that provides a description of my legal rights or procedural safeguards under the Individuals with Disabilities Education Act.

My signature below indicates that I have received these documents on the date specified.

_____ _____

***SIGNATURE OF PARENT, GUARDIAN, SURROGATE PARENT OR ADULT STUDENT** ***DATE**

Please refer to the page of the ***Notice of Procedural Safeguards*** for information regarding persons to contact if you should have any questions regarding this document.

ACUERDO DE SERVICIO PARTICIPATORIO DE EDUCACION ESPECIAL DE GREGG COUNTY

RECIBO DE

NOTIFICACION DE LAS SALVAGUARDAS DEL PROCEDIMIENTO: DERECHOS DE LOS PADRES DE ESTUDIANTES CON DISCAPACIDADES

(Revisado 2018 Julio)

NOMBRE DE ESTUDIANTE: _____ **FECHA DE NACIMIENTO:** _____

DISTRITO: _____ **CAMPUS:** _____ **GRADO:** _____

FECHA MANDADOS: _____

POR: ☐ Servicio Postal

☐ Entregados en persona por _____

☐ Mandados a casa con estudiante

☐ Otro metodo: _____

DOCUMENTOS PROVISTOS EN: ☐ Ingles ☐ Espanol ☐ Otro metodo: _____

Este document sirve para verificar que he recibido una copia de la **Notificacion de Procedimientos Salvaguardas: Derechos de los Padres de Estudiantes con Discapacidades** que me informa sobre el proceso por la cual un programa individual de educacion (IEP) es desarrollada para un(a) estudiante en un programa de educacion especial, y me informa sobre los derechos y las responsabilidades de los padres en este proceso.

Con mi firma declare que he recibido este documento en la fecha indicada.

_____ _____

Firma de Padres, Tutor, Padre Sustituto, Estudiante de Edad **Fecha**

Si usted necesita ayuda en entender cualquiera de los documento, por favor consulte, **Derechos de los Padres de Estudiantes con Discapacidades** para informaciones.

COMPLETE ONLY IF STUDENT IS ELIGIBLE FOR MEDICAID

PARENT NOTIFICATION TO RELEASE INFORMATION FOR SCHOOL BASED MEDICAID SERVICES IN TEXAS

STUDENT ID: _____ STUDENT NAME: _____ AGE: _____

DOB: _____ GENDER: ☐Male ☐Female GRADE: _____ DISTRICT: _____

HOME CAMPUS: _____ CURRENT CAMPUS: _____

ACADEMIC YEAR: _____ Date: _____

Dear Parent/Adult Student:

The Texas Health & Human Services Commission (HHSC) and the Texas Education Agency (TEA) established the School Health and Related Services (SHARS) program to enable school districts to seek reimbursement from the state for certain services provided to students who qualify for special education. SHARS is a program under the Early and Periodic Screening, Diagnosis and Treatment Program which has no set limitations or cap on Medicaid services to clients 20 years of age or younger, so long as the service is medically necessary. Medicaid reimbursement funds generated from the SHARS program help to support health services for all students in the special education program by providing the district funds for additional staff and services.

This letter is to provide you with the required written notification of the school district's intent to seek reimbursements for services that are listed in your student's Individual's Education Program (IEP) and to inform you of your rights.

The school district will need to disclose your student's personally identifiable information to the State Medicaid agency to seek reimbursement for services provided to your student. The personally identifiable information consists of records or information about your student such as name, date of birth, special education disability and the services indicated in his/her IEP. These services may include Speech Therapy, Transportation, Personal Care, Nursing, Occupational Therapy, Physical Therapy, Counseling, Psychological Services and/or Testing.

The school district assures that:

- You, the parent, will not incur out-of-pocket expenses for your student to receive any of these services.
- You, the parent, will not be required to sign up for public benefits in order for your student to receive any of these services.
- The district's participation in the SHARS Program does not preclude your student from receiving similar or additional services by parent choice under another Medicaid Program or provider in the private sector.
- You, the parent, have the right to revoke consent at any time, and the district must still provide the services indicated in your child's IEP at no charge to you.

If you should have any questions or need assistance, please contact: Dorothy Poteet at 903/984-4416

COMPLETE ONLY IF STUDENT IS ELIGIBLE FOR MEDICAID

PARENT CONSENT TO RELEASE INFORMATION FOR SCHOOL BASED MEDICAID SERVICES IN TEXAS AND CONSENT FOR DISTRICT TO SEEK MEDICAID REIMBURSEMENT FOR SPECIAL EDUCATION SERVICES DETERMINED BY STUDENT'S IEP TEAM

STUDENT ID: _____ STUDENT NAME: _____ AGE: _____

DOB: _____ GENDER: ☐Male ☐Female GRADE: _____ DISTRICT: _____

HOME CAMPUS: _____ CURRENT CAMPUS: _____

ACADEMIC YEAR: _____ Date: _____

Dear Parent/Adult Student

Under the Family Education Rights and Privacy Act (FERPA), the school district indicated above is mandated to obtain initial parental consent prior to disclosing the personally identifiable information required for billing the State Medicaid agency. We need your informed consent prior to seeking reimbursement for the medical services provided. Your rights are explained in the Parent Notification to Release Information for School Based Medicaid Services in Texas which you received with this request for consent. Once initial consent is given, the district will provide you with annual written notification of its intent to continue to seek Medicaid reimbursement for your student.

If you should have any questions or need assistance, please contact: Dorothy Poteet at 903/984-4416.

Please return this letter signed and dated to the following address and retain a copy for your files:

Gregg County SSA
Attn: Dorothy Poteet
5303 Old Hwy 135 N
Gladewater, TX 75662

I, the Parent/Guardian/Adult Student agree to the following statements:

- I have been informed in my native language about the School Health and Related Services (SHARS) program.
- I consent to the release of information necessary for the school district to receive Medicaid benefits.
- I give my consent for the school to access my student's public Medicaid benefits for services described in his/her IEP now or if he/she becomes eligible prior to expiration of this consent.
- I understand that once initial consent is given, the school district will provide annual written notification to me of its intent to continue to seek Medicaid reimbursement.
- I understand that I can revoke future consent at any time.
- I understand that if I do not provide consent now or revoke consent in the future, the school district must still provide the services indicated in my student's IEP at no charge to me, the parent.

☐ Yes ☐ No

_____ _____

***SIGNATURE OF PARENT, GUARDIAN, SURROGATE PARENT OR ADULT STUDENT** ***DATE**

_____ _____

***SIGNATURE OF INTERPRETER, IF USED** ***DATE**

CONSENT TO RELEASE INFORMATION TO AGENCIES FOR TRANSITION-RELATED PURPOSES

COMPLETE ONLY IF STUDENT IS AGE 15 OR OLDER

STUDENT ID: _____ STUDENT NAME: _____ AGE: _____

DOB: _____ GENDER: ☐Male ☐Female GRADE: _____

HOME CAMPUS: _____ CURRENT CAMPUS: _____

ACADEMIC YEAR: _____ Date: _____

We are asking that you authorize the agency(ies) named below to disclose to each other confidential information regarding the above named student and to invite said agencies to transition-related meetings.

☐Texas Education Agency (TEA)
☐Texas Employment Commission (TEC)
☐Texas Juvenile Justice Department (TJJD)
☐Texas Department of Community Affairs
☐Texas Higher Education Coordinating Board (THECB)
☐Department of State Health Services
☐DARS Deaf & Hard of Hearing Services
☐Department of Family & Protective Services
☐Texas Commission for the Blind (TCB)
☐Texas Juvenile Probation Commission (TJPC)
☐Texas Workforce Commission/Texas Workforce Solutions
☐Texas Department of Housing & Community Affairs (TDHCA)
☐Department of Health & Human Services (TDHS)
☐Department of Assistive & Rehabilitative Services (DARS)
☐Department of Aging & Disability Services
☐Early Childhood Intervention

The purposes of the disclosure are to determine if the student may qualify for the agencies' services, to facilitate evaluation for services from the above agencies, and to assist in transition planning.

If you want more information or have questions, please contact:
School Staff Member _____ Phone Number: _____

Staff Email: _____

☐ Yes ☐ No **I have been fully informed and do understand the school's request for my consent for the release of the student's records.**

☐ Yes ☐ No **I have been fully informed and do understand the school's request for my consent for the release of the student's records.**

_____ _____
***SIGNATURE OF PARENT, GUARDIAN, SURROGATE PARENT OR ADULT STUDENT** ***DATE**

_____ _____
***SIGNATURE OF INTERPRETER, IF USED** ***DATE**

Please return from to: _____ at _____