

**Region 14 – Hopewell Center
 Consultation/Evaluation Referral Packet
 For Children 3 to 22 Years Old
 (Revised for 09-10 school year)**

Please use this packet to request the following Hopewell services:

➤ MFE (re-evaluation)

Please:

- 1. Provide the child’s name and social security number below,**
- 2. Sign below, and**
- 3. Send this page along with all information listed for the MFE Re-evaluation you are requesting.**
- 4. Send to Region 14 - Hopewell Center attention Diane Mason.**

Thank You!

I am requesting Region 14 - Hopewell Center provide the service(s) indicated below for;

 Child’s Name

 Child’s Social Security Number

Reevaluation (or second opinion re-evaluation)

- Copy of Student Information form
- Copy of current IEP
- Copy of last Evaluation Team Report
- Copy of Parent Consent for Evaluation (Form PR-05)
- Hopewell Planning Form page for Preschool or for School-Age
- Authorization for Release of Information
- NOTE: Please provide parents with Medicaid information sheet

Please indicate if student is P/S or School Age, type of referral & due date:

_____ *Preschool*

_____ *School Age*

- | | | |
|--------------------------|---------------------------|-----------------------|
| <input type="checkbox"/> | Transition Meeting | due date _____ |
| <input type="checkbox"/> | Initial Evaluation | due date _____ |
| <input type="checkbox"/> | Re-evaluation | due date _____ |

Has student been identified with a disability?	_____ Yes	_____ No
Is student on an IEP?	_____ Yes	_____ No
Is student on a 504 ?	_____ Yes	_____ No

 District Contact Person Signature

 District

 Date

STUDENT INFORMATION

Identifying Data

Name: _____

Father: _____

Date of Birth: _____

Address (if different than student): _____

Address: _____

Phone (if different then student): _____

Phone: _____

Mother: _____

Legal Guardian: _____

Address (if different than student): _____

Address (if different than student): _____

Phone (if different than student): _____

Phone (if different than student): _____

Parent(s) Native Language (if not English) _____

Student's Native Language (if not English) _____

Grade: _____ EMIS/Student Number: _____ Current Disability Condition: _____

Building of Current Attendance: _____

Present Teacher(s): _____

Date of Reevaluation Plan: _____

Reevaluation Completion Date: _____

Summary of background information and services provided to the student:

PR-05 PARENT CONSENT FOR EVALUATION

TYPE OF EVALUATION

Initial Evaluation

Reevaluation (if additional assessment is to be conducted)

PART 1: TO GRANT CONSENT

I HEREBY GIVE MY PERMISSION FOR _____ to receive an evaluation(s) by designated personnel. I understand the evaluation information will be shared by teachers, principals, and other appropriate school personnel, and that the school district will forward educational records upon request to another school district or educational agency in which my child seeks or intends to enroll. I further understand that my granting of consent is voluntary on my part and I may revoke my consent at any time.

I have received a copy of my procedural safeguards and I understand the information provided.

Signature of parent/legal guardian/custodian, or student (if age 18 or older) _____ Relationship to Child _____ Date _____

PART 2: TO REFUSE CONSENT

(Do Not complete Part II if you completed Part I)

I have received a copy of my procedural safeguards and I understand the information provided.

I DO NOT GIVE MY PERMISSION for an evaluation for: _____

Reasons: (It would be helpful to school personnel who are designing an educational program to meet your child's unique needs if you would share with us your reasons for not giving your permission for an evaluation.)

Signature of parent, legal guardian, custodian, or student (if 18 or older) _____ Relationship to Child _____ Date _____

PART 3 (To be completed by the school)

Information about the evaluation and a copy of the procedural safeguards notice were presented/sent by:

Signature of school district representative _____ Date(s) _____

The parents' native language is _____

If not English, was the information provided in the native language or other mode of communication of the parents? YES NO

If no, explain:

If the native language or other mode of communication is not a written language, attach documentation of the steps taken to ensure that the notice was explained and that the parent understands the content of the notice.

Hopewell Evaluation Planning Form
Preschool

Child's Name: _____ Date of Birth: _____
Area(s) of Suspected disability: _____

Please check the assessment information you are requesting Hopewell Staff to provide:

- Pre-Academic/academic skills
- Adaptive Behavior
- Assistive Technology Needs
- Behavior Measure
- Cognitive Ability
- Hearing Abilities
- Motor Abilities
- Observation
- Social/Emotional Status

Hopewell Evaluation Planning Form
School-Age

Child's Name: _____ Date of Birth: _____
Area(s) of Suspected Disability: _____

Please check the assessment information you are requesting Hopewell Staff to provide:

- Achievement
- Adaptive Behavior
- Assistive Technology Needs
- Behavior Measure
- Classroom Observation
- Hearing Abilities
- Cognitive Ability
- Motor Abilities
- Social/Emotional Status
- Vision Abilities

Authorization for Release of Information

___ **Southern Ohio ESC**
135 N. High Street
Hillsboro, Ohio 45133
Phone: (937) 393-1331
Fax: (937) 393-5394

___ **Region 14 – Hopewell Center**
5350 West New Market Road
Hillsboro, Ohio 45133
Phone: (937) 393-1904
Fax: (937) 393-0496

TO: _____ RE: _____
(Student Name)

(Street address)

(City, State and Zip Code)

We are requesting the following information/records for the above-named student:

___ All personally identifiable data on file, except: _____

___ the following records only: (please specify)

Reason for request: (please check)

___ To aid in making present and future educational decisions.

___ Other: (please specify)

I authorize you to release and exchange the indicated information regarding the above-named student verbally and in writing.

(Signature of parent/guardian or student, if 18 or older) _____
(Date)

(Street, City, State and Zip Code)

Note: Any redisclosure of the information release to you under this consent is prohibited without the express written consent of the client (ODMH 5122-27-09). This consent is subject to revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it (OAC 3791:2-1-01 (H) (8)). This information has been disclosed to you from recorded protected by Federal Confidentiality Rules. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client (OAC 3793:2-1-06 (I)).

Revocation of Consent

This release of information may be revoked by me at any time. No further disclosure shall be made upon my revocation of consent.

Relationship _____ Date signed _____

Relationship _____ Date signed _____

Dear Parents/Guardians:

We would like to notify you that Region 14 – Hopewell Center has become eligible to receive Medicaid reimbursement for Augmentative Communication, Audiological, Speech Therapy Service, Occupational Therapy Services, Physical Therapy Services and Psychological Assessments. Unless we receive a note of denial or a phone call from you, we will be billing Medicaid for your child.

If you have any questions, please call Diane Mason at Region 14 – Hopewell Center, 937-393-1904 ext. 115.

Thank you.