TRANSFER ARD PACKET CHECKLIST

1. Person responsible for Transfer ARD must:
   - Convene ARD meeting with the following members: (parent/guardian/adult student, administrator, regular and special education teacher);
   - and
   - Present recommendations from ARD members who are not able to attend and have the parent agree in writing to excuse the members.

2. Complete "Notice of ARD Committee Meeting" and have parent sign.

3. Give “Explanation of Procedural Safeguards” to parents; complete “Receipt for Explanation of Procedural Safeguards” and have parent sign it.

4. Complete the 5 page ARD/IEP form. Make sure demographics at the top of page one (1) are complete. Call previous school and verify attendance, schedule, and disability if the parent doesn’t have a copy of the latest IEP. Use information from the previous school to complete pages 1 and 2.

5. Complete page 3 - “IEP for Temporary Placement”; IEP duration is 30 school days; do not count school holidays and weekends.

6. Complete page 4 – “Schedule of Services”; indicate if subject is in regular or special education and the number of minutes of each class. Complete the needed accommodations and modifications for each subject. If related services were provided at the previous school, complete the bottom of the page accordingly. Complete State Testing information based on recommendations from previous school.

7. Complete page 5 - Get signatures of committee members who are present, check the ones who have been excused from attendance by the parent, excused member must attach recommendations.

8. Have parent complete and sign: Information from Parent; Home Language Survey; Consent for Assessment; SHARS Consent; and Notice for Release/Consent to Request Confidential Information.

9. Complete Transportation Information only if student gets special transportation. FAX copy to Transportation Department.

10. Give the completed Transfer ARD packet to the campus Diagnostician or Speech Therapist (if it is a Speech Only student). Timelines are critical in this process.
INVITATION TO MEETING

Student Name

Date

☐ Sent
☐ Given
☐ Mailed

Dear Parent:

We would like to invite you to attend an IEP Committee meeting to discuss educational programming for your child. We encourage you to attend this meeting, as your involvement is an important part of your child's education. (Note: If graduation is being discussed, it is a change of placement and, upon graduation, a student is no longer eligible for services under IDEA and graduation with a regular high school diploma terminates entitlement to the Foundation Schools Program benefits.)

Meeting Date: __________________________ Meeting Time: ________________
Place: _________________________________ Room Number: ________________

* The purpose of the meeting is to:

☐ Discuss, at your request, any educational or related service not proposed below;
☐ Initiate special education services if your child meets eligibility criteria;
☐ Review your child's program (including results of any new evaluations);
☐ Develop and/or review the Individual Education Plan (IEP) for your child;
☐ Consider Extended School Year Services;
☐ Review the Individual Transition Plan (ITP) and consider transition services.
☐ Other: Graduation/Dismissal

* Option(s) considered before proposing this meeting:

☐ Parent/Teacher conference
☐ Continue to rely on previous evaluation/eligibility
☐ Continue to rely on current placement/IEP
☐ Continue current elements of FAPE
☐ Other 1: ___________________________________________
☐ Other 2: ___________________________________________

* Reason(s) action(s) proposed:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

* Why option(s) were rejected:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

* The following persons have been asked to attend this meeting: (Refer to the Notice Response Form for additional attendee information)

☐ Parent/adult student
☐ Special Education representative
☐ Instructional representative
☐ Assessment/Evaluation staff personnel
☐ School Administrator
☐ Vocational Education representative
☐ Counselor
☐ Other:
☐ Other 1: ___________________________________________
☐ Other 2: ___________________________________________
☐ Other 3: ___________________________________________

* The following agencies have been invited to send a representative:

______________________________________________________________________________

(Note: You are welcome to bring with you any additional individual(s) who, in your judgment, have special knowledge or expertise regarding your child. If you plan to bring others with you, please notify us in advance at the number below.)

* The following evaluation procedures, tests, records, or reports will be reviewed and discussed:

☐ Full and Individual Evaluation (FIE)™ (e.g., language, physical, emotional/behavioral, sociological, intellectual, educational performance);
☐ School permanent records (e.g., grades, attendance reports, teachers' observations, achievement test scores, discipline reports);
☐ Independent evaluation reports;
☐ Parent information; and/or
☐ Other: ___________________________________________

* Other factors relevant to this IEP Committee meeting: None

The district does not discriminate on the basis of gender, disability, race, color, age or national origin in its education programs, activities, or employment as required by Title IX, Section 504 and Title VI.

The functions of an IEP committee are to determine eligibility, determine needed evaluation data, consider results of new evaluation, consider disciplinary change or placement (including a functional behavior assessment, behavior intervention plan, and a manifestation determination), develop or revise an Individual Education Program (including addressing new information, lack of expected progress or anticipated needs), make a change of placement, and to determine dismissal or graduation. Other concerns or needs may be appropriately addressed through parent/teacher conferences, conferences with the principal or special education coordinator, or through accessing procedures available through Board policy, including the complaint policy.

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 at least once a year. A full explanation of all procedural safeguards is included with this form. Please contact ESC Region VI (928) 438-2133 if you have any questions or need names of other individuals to assist you in understanding this document or your procedural safeguards.

Please KEEP THIS PAGE for your records. RETURN THE ATTACHED PAGE 2 to me. If you have any questions, please call me.

Staff Member __________________________ Position __________________________ Phone Number __________________________

1 You were previously sent the Notice of Assessment/Evaluation which described the evaluation procedures and tests which will be used to determine your child's educational needs.

* Denotes required items for all IEP meetings.

** Denotes additional required items for an IEP meeting called to discuss initiation of or change in placement, identification, or evaluation.
NOTICE RESPONSE FORM

Please check the appropriate statement(s) below and return:

☐ I will attend the meeting on (date): ____________________________ at (time): ____________________________.

☐ I am unable to attend the meeting at the suggested time; please contact me at ____________________________ to reschedule.

☐ I will not be able to attend the meeting; please have it without me. I wish to be notified of the results of the meeting.

☐ I will not be able to attend the meeting in person, but would like to participate via telephone.

Please contact me at ____________________________ at the scheduled meeting time.

☐ Yes ☐ No I have been informed of the IEP in my native language.

☐ Yes ☐ No I have been fully informed and do understand the IEP process and why it is being recommended for my child/me.

☐ I waive the required five school day waiting period between NOTICE OF THE IEP COMMITTEE MEETING and the IEP COMMITTEE MEETING.

A member of the IEP Team (as defined by TEA) shall not be required to attend an IEP meeting, in whole or in part, if the parent of a child with a disability and the local education agency agree that the attendance of such member is not necessary because the member's area of the curriculum or related services is not being modified or discussed in the meeting. Additionally, a member of the IEP team may be excused from attending an IEP meeting, in whole or in part, when the meeting involves a modification to or discussion of the member's area of the curriculum or related services, if:

- the parent and local education agency consent to the excusal; AND
- the member submits in writing to the parent and the IEP team, input into the development of the IEP prior to the meeting.

IDEA 2004: (H.R. 1350)

The local education agency (LEA) is requesting the following IEP Committee member(s) be excused:

<table>
<thead>
<tr>
<th>Committee Member</th>
<th>Recommendations Attached</th>
<th>Parent Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Assessment</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>☐ Instruction</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>☐ Special Education</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>☐ Speech Therapist</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>☐ Other: _________________________</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>☐ Other: _________________________</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

If you disagree with a LEA attendee request, please indicate in the "Comments" field below the reason for denying the request.

Comments:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature of Parent, Guardian, Surrogate Parent or Adult Student

Date

Signature of Interpreter, if used

Date

The district does not discriminate on the basis of gender, disability, race, color, age or national origin in its education programs, activities, or employment as required by Title IX, Section 504 and Title VI.

Medicaid #_________________
LIVINGSTON ISD SPECIAL SERVICES
Livingston, Texas
TRANSFER ARD / IEP MEETING

Meeting Date: ________________

Student Name: ___________________________ Ethnicity: ______ Race: ______

SS#: ________________________________ Instructional Arrangement Code: ______

Student ID #: __________________________ Parent's Name: ____________________

Birth Date: ___________________________ Address: _________________________

Campus: ______________________________ ________________________________

Grade: _______ Sex: □ Male □ Female Home Phone: _________________________

Work Phone: __________________________ Cell Phone: ______________________

□ An interpreter was used to assist in conducting the meeting. If yes, specify language: _______________________

□ Parent/adult student waives the (5) school day written notice of the IEP meeting and agrees to an earlier meeting.

A member of the IEP Team (as defined by TEA) shall not be required to attend an IEP meeting, in whole or in part, if the parent of a child with a disability and the local education agency agree that the attendance of such member is not necessary because the member's area of the curriculum or related services is not being modified or discussed in the meeting. Additionally, a member of the IEP team may be excused from attending an IEP meeting, in whole or in part, when the meeting involves a modification to or discussion of the member's area of the curriculum or related services, if:

• the parent and local education agency consent to the excusal; AND
• the member submits in writing to the parent and the IEP team, input into the development of the IEP prior to the meeting. IDEA 2004: (H.R. 1350)

□ All IEP Committee members will be in attendance.
□ A list of members who were not required to attend or who are excused by parent and LEA agreement can be found on the signature page of this IEP.

I. REVIEW OF ASSESSMENT DATA

□ Full Individual Evaluation (FIE) Date: ___________________________

□ Psychological Evaluation Date: ___________________________

□ Speech Evaluation Date: ___________________________

□ Counseling Evaluation Date: ___________________________

□ Other: ___________________________ Date: ___________________________

□ Other: ___________________________ Date: ___________________________

□ Additional assessment is needed. If so, type of assessment: ___________________________

Due by: ___________________________

Medicaid ID#: ___________________________
II. AREA(S) OF DISABILITY: Indicate (1) PRIMARY and (2) SECONDARY disabilities in ( ).

☐ □ Learning Disabled – Indicate Specific Learning Disability area(s):
☐ Basic Reading
☐ Math Calculation
☐ Reading Comprehension
☐ Written Expression
☐ Reading Fluency
☐ Math Problem Solving
☐ Oral Expression
☐ Reading Comprehension

☐ □ Other Health Impairment: ☐ ADD/ADHD ☐ Other: ______________________________

☐ □ Speech Impairment ( ) ☐ Emotionally Disturbed ( ) ☐ Intellectual Disabilities
☐ AI ( ) ☐ VI ( ) ☐ Autistic ( ) ☐ Orthopedic Impairment ( ) ☐ NCEC

☐ The parent/guardian verifies that the student was receiving special education services in:

______________________________________________ (School District)

______________________________________________

FAX: ______________________________________

Verification from the former district was reported by:
☐ Telephone – Staff Person Contacted: ______________________________
☐ Written Documentation – Date Received: ______________________________

The instructional arrangement and related service provided in the previous district were as follows:

Eligibility is temporary and contingent upon receipt of valid assessment data or collection of new assessment data. A second IEP Committee meeting will be held within (30) school days to develop an IEP based on assessment data available at that time.

☐ Yes ☐ No The IEP previously developed was reviewed and remains in effect.
☐ Yes ☐ No An interim placement has been determined. The IEP will be finalized within (30) school days.

III. COMPETENCIES
☐ Discussed below
☐ To be addressed at (30) day IEP Meeting

A. Physical – as it affects participation in Instructional Settings:
☐ Normal Vision
☐ Normal Vision (with glasses)
☐ Normal Hearing
☐ Good general health

Physical – as it affects participation in Physical Education:
☐ Yes ☐ No The student is capable of receiving instruction in regular P.E. with no modifications. If no, see services to be provided (page 4).

B. Behavioral – as it affects educational placement/programming: (check appropriate competencies)

☐ Interacts appropriately with peers
☐ Adjusts easily to new situations
☐ Cooperative
☐ Other: ______________________________________

☐ Interacts appropriately with adults
☐ Respects authority
☐ Completes tasks
☐ Other: ______________________________________

IV. IEP GOALS
☐ An IEP goal is attached (see page 3 of 5)
☐ Refer to previous IEP goals, as no changes are being made at this time.

V. ASSISTIVE TECHNOLOGY
☐ NO ☐ YES Explain: ________________________________________________

VI. LEAST RESTRICTIVE ENVIRONMENT
☐ Yes ☐ No The student is being educated with regular education students to the maximum extent appropriate to the needs of the student and is unable to benefit from education with regular education student to any greater extent.

Medicaid ID#: ______________________________
Livingston ISD Special Services
INDIVIDUAL EDUCATIONAL PROGRAM (IEP) GOAL

[ ] INSTRUCTIONAL SERVICES
[ ] RELATED SERVICES
SPECIFY: ________________

IEP DATE: ____________________________

[ ] ACCEPTED BY IEP COMMITTEE

_______________________________
Name of Student

_______________________________
ID Number / SS#

From: ____________
To: ____________
Duration of Services

_______________________________
School

______________________________
Grade

______________________________
Language of Delivery

☐ ESL  ☐ Bilingual

PARENT NOTIFICATION STATEMENT
Written IEP Progress Reports will be provided to the student’s parent(s)/guardian(s) at the end of every grading period to regularly inform parent(s)/guardian(s) of their children's progress toward meeting annual IEP goals. These Progress Reports are provided on the same timely basis as are provided to parent(s)/guardian(s) of non-disabled children, and are in addition to the regular reporting for all children.

INSTRUCTIONAL AREA

LOCATION

☐ Special Education  ☐ General Education

☐ Other ________________

PRESENT LEVELS OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

GOAL: To collect data for the purpose of developing goals and objectives for appropriate educational placement/programming.

<table>
<thead>
<tr>
<th>SHORT TERM OBJECTIVES</th>
<th>LEVEL OF MASTERY CRITERA</th>
<th>METHOD OF EVALUATION</th>
<th>EVALUATION CODES</th>
<th>EVALUATION CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in informal assessment procedures to determine competencies, strengths, and weaknesses. These findings will be used for instructional purposes until a complete IEP is formulated at the second IEP meeting.</td>
<td>70%</td>
<td>1-6</td>
<td></td>
<td>□ YES  □ NO</td>
</tr>
<tr>
<td>Maintain a passing grade in all classes for the reporting period based on the accommodations/modifications approved in this IEP report for eligibility to participate in extracurricular activities.</td>
<td>70%</td>
<td>1-6</td>
<td></td>
<td>□ YES  □ NO</td>
</tr>
</tbody>
</table>

METHOD OF EVALUATION

1 = Teacher Made Tests  5 = Conferences
2 = Observations        6 = Work Samples
3 = Weekly Tests        7 = Portfolios
4 = Unit Tests          8 = Other

EVALUATION CODES

* = Not Yet Addressed  N = Not Mastered
C = Continue           W = Work In Progress
D = Discontinued       Y = Mastered
M = Mastered

Medicaid ID#: __________________________
VI. DETERMINATION OF SERVICES TO BE PROVIDED

(Justification indicates that the identified placement is in the least restrictive environment and is based on the needs of the student. Alternative placement was discussed.)

ARD Date: __________________ School Year: __________________ Duration: __________________

Student's placement this year will be at: _____________________ (Campus)

<table>
<thead>
<tr>
<th>Subject</th>
<th>Service Provider</th>
<th>Grade Assigned by</th>
<th>Reg. Ed. Minutes</th>
<th>Sp. Ed. Minutes</th>
<th>Modifications/Accommodations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regular Minutes are provided in the Regular Education setting. Special Ed. Minutes and/or Related Services are provided outside the regular education setting.

Accommodations / Modifications

| 1. Modified Tests | 7. Shortened Assignments | 13. BIP |

Additional modifications may be listed in the deliberations. Modifications needed to ensure success in regular, remedial, and supportive programs including eligibility for participation in extracurricular activities are specified on the IEP.

<table>
<thead>
<tr>
<th>Related Service</th>
<th>Provider</th>
<th>Minutes</th>
<th>Frequency</th>
<th>Direct</th>
<th>Consult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>times per</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>times per</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In order to receive passing grades in all content areas of instruction and to participate in extracurricular activities, the expected mastery level as established by the district is 70% unless otherwise stated. Exceptions for this student, if any, are documented in the IEP.

STATE TESTING:  □ Not offered for this grade

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>STAAR</th>
<th>STAAR A</th>
<th>STAAR ALT 2</th>
<th>EOC</th>
<th>Accommodations / Modifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Writing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Math</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Science</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Studies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medicaid ID#: __________________
VII. ASSURANCES
The committee assures the following: that special education placement is as close as possible to the student's home; that for national origin minority group students or linguistically different students, placement is not based on criteria which were developed solely on command of the English language; and that placement is based on peer-reviewed research to the extent practicable.

Basis for assurances: [ ] adaptations in testing procedures [ ] review of parent/student information
[ ] use of interpreter [ ] review of language assessment

The committee assures that special education placement is not based on deficiencies identified as directly attributable to a different culture, lifestyle, or lack of educational opportunities.

Basis for assurances: [ ] review of parent/student information [ ] review of sociological assessment

The district does not discriminate on the basis of gender, disability, race, color or national origin in its education programs, activities, or employment as required by Title IX, Section 504 and Title VI.

☐ I waive the 5-day written notice requirement prior to implementing services agreed upon in this ARD, and I understand that this document will serve as my prior written notice.

☐ The 5-day written notice requirement has not been waived.

*The ARD committee assures that this student is being educated with students his/her age who do not have disabilities to the maximum extent appropriate to his/her overall educational needs (including academic and developmental areas such as language and socialization).

*The committee assures that all instruction and related services specified in the ARD/IEP will be provided to the student at no cost. Fees normally charged to students without disabilities or their parents as part of the general education program may be charged (i.e., art or lab fees).

*The district assures that each teacher who provides instruction to a student with disabilities will receive relevant sections of the student's current ARD/IEP, and that each teacher will be informed of specific responsibilities related to implementing the ARD/IEP, such as goals and benchmarks, and of needed accommodations, modifications, and supports for the child.

VIII. SIGNATURES OF COMMITTEE MEMBERS

<table>
<thead>
<tr>
<th>Signature</th>
<th>Position</th>
<th>Agree</th>
<th>Disagree</th>
<th>Excused</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Adult Student</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instruction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Yes ☐ No

SHARS Consent Date: ___________

☐ This IEP has been developed by the members of the ARD Committee by mutual agreement.

☐ The members of this ARD Committee have not reached mutual agreement. The school has offered and the parent has agreed to a recess of not more than (10) school days. During the recess, the members shall consider alternatives, gather additional data, and/or obtain additional resource persons to enable them to reach mutual agreement. This recess does not apply if the student presents a danger of physical harm to him/herself or others, or if the student has committed an expellable offense. The ARD Committee will reconvene on:

Date: ___________ Location: ___________ Time: ___________

☐ The members of this ARD Committee have not reached mutual agreement.

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 at least once a year. A full explanation of all procedural safeguards is included with this form. Please contact ESC Region VI at (936) 435-8258 if you have any questions or need names of other individuals to assist you in understanding this document or your procedural safeguards.

1 Assessment personnel are required when interpretations of assessment data are being considered.

2 Include documentation concerning the reconvened ARD.

Medicaid ID#: ____________________
Recommendations to the ARD / IEP Committee
Student Transferring from another School District

Date: 

Student: 

Campus: 

Recommendations include:

- Review the ARD / IEP developed prior to transfer and provide commensurate services and placement
- Accept and implement the goals and objectives approved by the prior ARD / IEP Committee if appropriate or develop interim goals

Additional Comments:


Signatures:

Special Education

Instruction

Assessment

Speech Therapist

Certified Teacher of Visually Impaired

Other

Other
Livingston Independent School District
P.O. Box 1297 - Livingston, Texas 77351
Phone: (936) 328-2320 - Fax: (936) 328-2349
DIRECTOR: PAMELA MITCHELL

SHARS Information for Parent / Guardian

Student Name: ___________________________ Campus: ____________

☐ This document was sent ☐ mailed ☐ given to the parent(s)/guardian(s) on ___________

In January 1992, the Texas Department of Human Services (TDHS) established the School Health and Related Services (SHARS) program to enable school districts to become Medicaid providers of certain health related services. Under this program, school districts can be reimbursed for certain health related services rendered to exceptional education students who are also Medicaid eligible. Medicaid reimbursement funds generated from SHARS will help to enhance health related services for all exceptional educational students by providing the district funds for additional staff and services.

Based upon our evaluation of the SHARS program, we have determined that the district and its healthcare professionals are currently providing the level and quality of health related services as mandated and specified by Medicaid and the SHARS program. If you should have any questions or need assistance, please contact: Nina Randolph, Medicaid Billing Secretary, at (936) 328-2320.

The Texas Department of Human Services (TDHS) has established that the district has qualified as a provider for SHARS. The TDHS determined that the district meets state educational agency approved or recognized certification, licensing, or other requirements that were found to be consistent with state and federal laws that apply to the SHARS program. As a SHARS provider, the district has been approved to seek reimbursement for the following School Health and Related Services:

Audiology  Personal Care Services  School Health Services  Speech Therapy
Counseling  Psychological Services  Occupational Therapy  Social Services (Social Worker)
Evaluations  Psychological Testing  Physical Therapy  Transportation
Medical Services

The Medicaid Agency further mandates that before Medicaid reimbursement can occur, the district must meet the following Medicaid requirements:

1. The student must be Medicaid eligible at the time of the service.
2. The student must be under 21 years of age with disability.
3. The school health and related services the student receives must be stated in the student's Individual Education Plan (IEP).
4. The district must meet compliance with all applicable federal, state, and local laws and regulations regarding the services provided.
5. The district must maintain and must submit all records and reports required by the Medicaid Agency (TDHD) to ensure compliance with the established IEP.
6. Parents will not incur out-of-pocket expenses or be required to sign up for public benefits in order for their child to receive services.
7. The district will not use benefits that would decrease a child's lifetime coverage or result in the family paying for services that would otherwise be covered.
8. The district will not use benefits that would increase premiums, lead to the discontinuation of benefits or risk loss of eligibility for home and community-based waivers.

Finally, please note that the district's participation in the SHARS program does not preclude a child from receiving similar or additional services by parent choice under another Medicaid program or provider in the private sector.

☐ Yes ☐ No

I/we have been informed in my native language about the School Health and Related Services (SHARS) program.
I/we give my/our consent for the school district to access this student's Medicaid benefits now or if he/she becomes eligible prior to expiration of 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 also understand that giving permission will not affect this student's future benefits.

Parent/Guardian/Adult Student Signature

Medicaid #:

Date

Revised 02/2017
Consent for Assessment / Evaluation

Date: ______________________

☐ Sent  ☐ Given  ☐ Mailed

Student Name: ___________________________ Date of Birth: ______________

We are asking for your permission to test your child/you to find out what your child/your educational needs are.

Please check the appropriate box. When you have finished, please sign your name with the date.

☐ Yes  ☐ No  I have been fully informed and do understand the assessment / evaluation process and why it is being recommended for my child/me.

☐ Yes  ☐ No  I give permission for testing. I understand that my consent for testing is voluntary and may be revoked at any time. However, I understand that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

☐ Yes  ☐ No  I waive the 5 school days’ notice testing can occur.

☐ Yes  ☐ No  I have received the Notice of Procedural Safeguards for Special Education.

☐ Yes  ☐ No  I have been informed of the evaluation in my native language.

If any statement is answered No, please explain: ____________________________________________________________

_________________________________________ Date
Signature of Parent, Guardian, Surrogate Parent, or Adult Student

_________________________________________ Date
Sign of Interpreter (if used)

Please return this form as soon as possible to:

_________________________________________ at ___________________________
School Staff Person School

If you have any questions, please contact:

_________________________________________ at ___________________________
School Staff Person School Phone Number

If you have any questions, please contact: Pamela Mitchell, Director (936)328-2320

8/2018
Livingston ISD Special Services

Receipt for

A Guide to the Admission, Review, and Dismissal Process

and

Notice of Procedural Safeguards
Right of Parents of Students with Disabilities

Student: ___________________________ DOB: ___________________

This receipt is to verify that I have received a copy of the following documents:

☐ A Guide to the Admission, Review, and Dismissal Process

☐ Notice of Procedural Safeguards
  Right of Parents of Students with Disabilities

These documents inform me of my rights throughout the child/student-centered educational process. I understand that my rights include the right to receive:

- this and all other notices in the language I understand (primary language) or, if needed, a translation of such orally, in sign language, or in Braille as appropriate, and;

- answers from school personnel to additional questions I may have.

My signature below indicates that I received copies of the documents on the date specified and that I understand their contents. I understand that school personnel will make an entry in my child’s file on the Dissemination Log that I received the documents.

Please sign, date, and return to school as soon as possible.

Staff Name

Signature of Parent/Guardian/Surrogate Parent or Adult Student

Position

Date Signed

Date Issued

Signature of Interpreter (if used)

Name of Student’s Current Campus

Date Signed
LIVINGSTON ISD SPECIAL SERVICES
P.O. Box 1297 ~ Livingston, Texas 77351
Phone: (936) 328-2320 ~ Fax: (936) 328-2349
DIRECTOR: PAMELA MITCHELL

Notice For Release / Consent To Request
Confidential Information

Date Sent / Mailed: ___________________________  □ Request Information  □ Release Information

Student: ___________________________  Date of Birth: ___________________________

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 school staff person:

Name and position of school staff person _______________________________________________________

Livingston ISD Special Services

Name of ISD / Special Education

Address: P.O. Box 1297
          Livingston, Texas 77351

Person / Agency to whom request is made

Person / Agency making request

Name of Person / Agency _________________________________________________________________

RECORDS TO BE RELEASED / RECORDS REQUESTED

□ Educational Referrals, Assessment, and ARD data  □ Psychological Assessment

□ Medical Records  □ Other: __________________________

PURPOSE OF DISCLOSURE

□ Educational Referrals, Assessment, and ARD data  □ Psychological Assessment

□ Medical Records  □ Other: __________________________

If you wish to have additional information or if you have any questions, please call (936) 328-2320.

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.

□ I understand that my consent is voluntary and may be revoked in writing at any time.

□ [*I understand that I will be notified in writing of each release of educationally related information.

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.

Signature of Parent, Guardian, Surrogate Parent, or Adult Student ___________________________

Date ___________________________

Signature of Interpreter, if used ___________________________

Date ___________________________

* Required only when a school district does not include in it’s policy a notice that educational records are forwarded to other agencies or institutions that have requested the records and in which the student seeks or intends to enroll.
**LISD TRANSPORTATION INFORMATION**

- Start Service
- Continue
- Change Pick Up/Drop Off
- Change Student Info
- Discontinue Service

- Other
- Date Services Begin: ______________________

<table>
<thead>
<tr>
<th>Student's Name:</th>
<th>Grade:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Campus:</td>
<td></td>
</tr>
<tr>
<td>Parent's Name:</td>
<td>Home Phone:</td>
</tr>
<tr>
<td>Home Address:</td>
<td>Work Phone:</td>
</tr>
<tr>
<td>Emergency Contacts: Home:</td>
<td>Work:</td>
</tr>
<tr>
<td></td>
<td>Cell:</td>
</tr>
</tbody>
</table>

**Background:**
- Ambulatory
- Diabetic
- Non-Ambulatory
- Non-Verbal
- Autism
- Hearing Impairment
- Other Health Impaired / Medically Fragile
- Visual Impairment
- Behavioral Concerns
- Communication Disorder
- Wheelchair
- Cognitive Disability
- Hemophilia
- Seizure Disorder
- Other: ______________________

**Competencies** (Indicate those relevant to successfully transporting this student):
- Can identify bus #
- Can sit independently
- Can visually locate seat & exits
- Can walk independently
- Can fasten seatbelt
- 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 speech, reading and/or gestures
- Other: ______________________

**Special Needs:**
- Bus Aide / Bus Monitor
- Has a BIP

**Medical / Medication:**
**Special Equipment:**
**Other Information:**

**Regular School Year**
**ESY**

**BEFORE SCHOOL PICK-UP**
From: ______________________ To: ______________________ Class Start Time: ______________________

**AFTER SCHOOL DROP-OFF**
To: ______________________ Class End Time: ______________________

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: (Name, address, phone).

- Yes
- No

(Alternate Address) Name: ______________________ Address: ______________________ Phone: ______________________

Parent/Adult Signature: ______________________ Campus/Admin. Signature: ______________________

**TRANSPORTATION DEPARTMENT USE ONLY:**

Begin Date: ______________________ AM Bus #: ________ SR Bus #: ________ PM Bus #: ________

Comment: ______________________ Assigned: ________
Information From Parent

Student: ____________________ Sex: □ M or □ F DOB: ______________ SS#: ____________

Parent/Guardian: ____________________ Home Phone: (____)__________

Address: ____________________ Work Phone: (____)__________

City: ____________________ Zip: ____________ Email Address: ____________________

District/Campus: ____________________ Grade: ________ Ethnicity: ________ Race: ________

Family and Home:

Home Language: □ English □ Spanish □ Other: ____________________

Father’s Name: ____________________ Occupation: ____________________

Mother’s Name: ____________________ Occupation: ____________________

Does student live with biological parents? □ Yes or □ No

If no, with whom does he/she live? ____________________

Does student live with foster parents? □ Yes or □ No

If yes, have the parents received surrogate parent training? □ Yes or □ No

Other children in home: ____________________ Other adults in home: ____________________

Have any important changes occurred within the family during the last two years? (Check all that apply)

□ Moves □ Births □ Deaths □ Illnesses □ Separations □ Divorce □ Job Changes

Is the student receiving services from Medicaid? □ Yes or □ No

If yes, Medicaid ID#: ____________________

Does student receive services from other agencies? ____________________

Previous evaluations pertaining to educational planning:

<table>
<thead>
<tr>
<th>Date</th>
<th>Agency / Individual</th>
<th>Type of Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Health and Physical:

Mother’s health during pregnancy: □ good □ poor □ RH □ Explain: ____________________

Baby’s health after birth: □ good □ poor □ Explain: ____________________

Are there any family health concerns you would like us to be aware of? □ Yes or □ No

If yes, please explain: ____________________

Do you believe any of the student’s following developmental skills were delayed?

□ Sitting alone □ Walking □ Crawling □ Bowel / Bladder Control □ Feeding / Dressing Self

□ Social Skills □ Speech □ Other: ____________________

Check (✓) if the student has any of the following:

□ Diabetes □ Epilepsy □ Asthma □ Seizures □ Head Injury □ Allergies

List any serious illnesses, accidents, injuries or operations: ____________________

Medication(s): (list name and dosage) Current: ____________________ Past: ____________________
Information From Parent

III. Behavior:

Sleep Patterns: □ sleeps well □ hard to get to sleep □ doesn’t sleep well □ wakes often □ wakes early

What activities does your child participate in at home? (Check all that apply)
□ Watches television □ Reads books □ Listens to music
□ Plays electronic games □ Plays with others □ Spends time on the computer
□ Participates in sports □ Prefers to be alone □ Sleeps more than usual

What factors are frequently displayed by your child at home? (Check all that apply)
□ Is honest □ Gets along with siblings □ Throws tantrums
□ Is helpful □ Follows adult requests □ Argues
□ Is responsible □ Has mood swings □ Disobeys
□ Respects others □ Hits and/or kicks others □ Withdraws

What methods of discipline are used at home? (Check all that apply)
□ Rewards for good behavior □ Assigned responsibilities □ Time Out
□ Verbal praise □ Early bedtime □ Spanking
□ Special privileges □ Removal of privileges □ Extra chores

How does your child respond to discipline at home? (Check all that apply)
□ Becomes obedient □ Throws tantrums □ Refuses to obey
□ Withdraws □ Cries □ Blames others
□ Throws or breaks things □ Hits and/or kicks □ Other:

Are you experiencing any problems with your child at home?

__________________________________________________________

Are there any concerns the school needs to be aware of?

__________________________________________________________

What suggestions could you give the school to help your child?

__________________________________________________________

__________________________________________________________

__________________________________________________________

Briefly discuss any other important information regarding your child:

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Parent/Guardian __________________________________________ Date ____________

Signature/position of person completing form, if obtained by parent interview 

__________________________________________________________

Date ____________

Revised 8/15

2 of 2
Home Language Survey

Student: ___________________________ Grade: ____________
Campus: __________________________

FILLED OUT BY PARENT OR GUARDIAN ONLY:

1. What language is spoken in your home most of the time? ______________________________________________________________________

2. What language does your child speak most of the time? ______________________________________________________________________

3. What language does your child understand best? ______________________________________________________________________

4. What language do you prefer to receive Special Education paperwork? ______________________________________________________________________

Signature of Parent or Guardian: ______________________________________________________________________ Date: __________

Cuestionario de Idioma Hogareño

Nombre del Niño(a): ___________________________ Grado: ____________
Escuela: ______________________________________________________________________

DEBE DE COMPLETARSE POR EL PADRE O GUARDIAN:

1. ¿Cuál es el idioma que más se habla en su hogar? ______________________________________________________________________

2. ¿Cuál es el idioma que más habla su niño(a)? ______________________________________________________________________

3. ¿Cuál idioma entiende su niño(a) mejor? ______________________________________________________________________

4. ¿En qué idioma preferiría usted recibir sus formas y Información de Educación Especial? ______________________________________________________________________

Firma del Padre o Guardian: ______________________________________________________________________ Fecha: __________