Livingston EDUCATIONAL SERVICE Agency

HOMEBOUND EDUCATIONAL SERVICES REFERRAL

Referral Date: _____ School Building: _____

Student Name: _____

Birth Date: _____ Gender: ☐ Male ☐ Female Grade: _____

Special Ed. Eligibility:	☐ Does Not Apply	☐ ASD	☐ D-B	☐ EI	☐ OHI	☐ SCI	☐ SLI	☐ TBI
		☐ CI	☐ ECSE	☐ HI	☐ PI	☐ SLD	☐ SXI	☐ VI

Medical Reason for Absence: _____ ☐ Physician's Statement Attached ***REQUIRED***

Start Date on Physician's Statement: _____ End Date on Physician's Statement: _____

Parent / Guardian: _____ Phone: _____

Address: _____

Student Schedule

Subject	Teacher & Teacher Email

Name of Person Making Referral: _____ Title: _____

Projected Duration: _____ to _____ Amount of Time per Week: _____

Superintendent / Designee Signature: _____ Date: _____

Required before services can begin *(includes approval of additional time for exams/testing/teacher consultation)*

Building Principal Signature: _____ Date: _____

Required before services can begin

Special Education Director Approval Signature*: _____ Date: _____

Required before services can begin (*only for students in Special Education)

When completed, send to: Executive Director of Special Education c/o Carol Braden
Livingston Educational Service Agency
1425 W. Grand River Ave.
Howell, MI 48843 **Fax:** 517-540-0535 **Email:** CarolBraden@LivingstonESA.org

Date Received by Livingston ESA: _____

Livingston ESA Approval: _____ Title: Executive Director of Special Education

Date Assigned: _____ Assigned To: _____

Copies of completed form sent to: ☐ LEA Special Education Office ☐ LEA HR Special ☐ LEA Referring School