Telephone: 906-863-5665

MENOMINEE COUNTY ISD
Intermediate School District

Fax: 906-863-7776

1201- 41st Avenue
Menominee MI 49858
Http://mc-isd.org

TRANSFER IN DOCUMENT CHECKLIST

Student's Name _____ Todays Date: _____

Please complete the forms below and attach the current IEP and MET from previous district and forward to the ISD:

____ Student Transfer-In / Temporary Placement Form

____ Notice for Initial Provision of Services and Programs (out-of-state) or regular Notice (in-state)

____ Medicaid Consent

____ Release of Information (if applicable)

____ Prescription Form if applicable (for Speech, PT, OT, Orientation and Mobility and Personal Care Services)

____ Copies of all Special Education records including but not limited to current IEP and MET

____ REED (if applicable)

____ Provide copy of Procedural Safeguards to parent/guardian

Please contact the Special Education Director (863-5665, x1012) with any questions or concerns.

Special Ed Teacher Assigned as Case Manager:

_____

TRANSFER-IN / STUDENT PLACEMENT

☐ Carney-Nadeau ☐ Stephenson ☐ Menominee ☐ North Central ☐ ISD

Transfer-In Date:	Student's Name:			
Date of Birth:	Sex:	Grade:	Race:	UIC#:
Mother/Guardian:		Father/Guardian:		
Mother Address:		Father Address:		
City, State, Zip:		City, State, Zip:		
Mother Phone:		Father Phone:		
Mother Email:		Father Email:		
Student's Primary Residence: □ Mother's Address □ Father's Address □ Shared Equally/Live Together				

CURRENT IEP INFORMATION:

Date of Current IEP:	Previous District:	Disability:	Is IEP Overdue? YES NO

Special Education Program(s) & Related Services in Current IEP (including frequency):

☐ Resource Room	_____ week/day/month	_____minutes	
☐ Speech	_____ week/day /month	_____minutes	☐Direct ☐Consult
☐ Social Work	_____ week/day /month	_____minutes	☐Direct ☐Consult
☐ Physical Therapy	_____week/day/month	_____minutes	☐Direct ☐Consult
☐ Occupational Therapy	_____week/day/month	_____minutes	☐Direct ☐Consult
☐ Other _____	_____week/day/month	_____minutes	☐Direct ☐Consult

After reviewing student's complete Special Education File, indicate ONE of the following choices:

☐ District will adopt student's current IEP and its timeline, as written from previous district (**in-state transfer only**).

☐ District will provide comparable programs and/or services and hold new IEP within 30 days (**out-of-state transfers, overdue IEPs and IEPs with programs/services not available. Out-of-state transfers require a REED**).

☐ Complete and attach ALL documents in Transfer-In Packet and return to MC-ISD (**including REED for out-of-state transfers**).

PARENT/GUARDIAN CONSENT:

☐ I have received a copy of the Procedural Safeguards and my parental rights have been explained to me. I consent to the identified placement.

☐ I do not consent for the district to adopt the Special Education program(s) and/or service(s) listed in my child's current IEP.

_____ _____

Parent(s)/Guardian Date

_____ _____

School District Representative Date

*Rule 340.1721 B(5) of the Michigan Revised Administrative Rules for Special Education states: *For students with an individualized education program in effect at a previous public agency who transfer public agencies within the same school year, the new public agency shall immediately provide a free appropriate public education. A decision regarding implementation of an individualized education program in accordance with 34 CFR 300.323 shall be made within 30 school days of enrollment.*

Notice for Provision of Services and Programs

The *Individuals with Disabilities Education Act* (IDEA) mandates that the district provide written notice to the parent when the district proposes to initiate or change the educational placement of the student or the provision of a Free Appropriate Public Education (FAPE) to the student; or when they refuse to initiate or change the educational placement of the student or the provision of a FAPE to the student.

You are receiving this notice for: _____.
(student name)

☐ You are receiving this notice because we are offering the provision of a FAPE. The programs and services will begin on _____ and will be located at _____. This proposal is the result of the Individualized Education Program (IEP) team meeting, dated _____, that was convened for the purpose of:

Check one of the following:

☐ Annual/Review IEP
☐ Reevaluation IEP

Check all others that apply:

☐ Change of Placement
☐ Suspension/Expulsion ☐ Graduation ☐ Other: _____
☐ Transition
☐ Change of Eligibility
☐ Other: _____

Upon district signature (see bold box below), this notice and the student's IEP constitute the district's offer of a FAPE.

☐ You are receiving this notice because we are offering the provision of a FAPE. This proposal is the result of the Individualized Education Program (IEP) Amendment, dated _____.

☐ You are receiving this notice because your student was found ineligible for special education programs and services at the Individualized Education Program (IEP) team meeting, dated _____, that was convened for the purpose of a reevaluation IEP.

The IEP describes each evaluation procedure, assessment, record, or report used in this offer of a FAPE. In the course of the development of the IEP, other options (e.g., programs and services, supplementary aids and services) considered but not selected were:

Option Considered but Not Selected	Reason Not Selected

☐ No other options were considered.

☐ Other factors that are relevant to the district's proposal or refusal (describe): _____
_____

☐ There are no other factors that are relevant to the district's proposal or refusal.

If the IEP team has determined that programs and services will be provided in a district other than the student's district of residence:

☐ The resident district authorizes/authorized the operating district _____ to conduct subsequent IEP team meetings.

☐ The resident district will conduct subsequent IEP team meetings.

The Procedural Safeguards Notice you received describes protections under the IDEA. The Procedural Safeguards Notice is also available at https://www.michigan.gov/documents/mde/Procedural_Safeguards_Notice_550307_7.pdf.

The following sources are available to assist you in understanding your rights:

_____.

X_____
Signature of Superintendent or Designee Date

Notice for Initial Provision of Services and Programs

The *Individuals with Disabilities Education Act* (IDEA) mandates that the district provide written notice to the parent when the district proposes to initiate or change the educational placement of the student or the provision of a Free Appropriate Public Education (FAPE) to the student; or when they refuse to initiate or change the educational placement of the student or the provision of a FAPE to the student.

You are receiving this notice for: _____.
(student name)

☐ You are receiving this notice because we are proposing to implement your student's initial Individualized Education Program (IEP) with the IEP team meeting date of _____. **Parent consent is required for the initial provision of programs and services within 10 calendar days (see shaded box below to provide consent).** Pending receipt of parent consent, the programs and services will begin on _____ and will be located at _____.

Upon district signature (see bold box below), this notice and the student's IEP constitute the district's offer of a FAPE.

☐ You are receiving this notice because your student was found ineligible for special education programs and services at the Individualized Education Program (IEP) team meeting, dated _____.

The IEP describes each evaluation procedure, assessment, record, or report used in this offer of a FAPE. In the course of the development of the IEP, other options (e.g., programs and services, supplementary aids and services) considered but not selected were:

Option Considered but Not Selected	Reason Not Selected

☐ No other options were considered.

☐ Other factors that are relevant to the district's proposal or refusal (describe): _____
_____

☐ There are no other factors that are relevant to the district's proposal or refusal.

If the IEP team has determined that programs and services will be provided in a district other than the student's district of residence:

☐ The resident district authorizes the operating district _____ to conduct subsequent IEP team meetings.

☐ The resident district will conduct subsequent IEP team meetings.

The Procedural Safeguards Notice you received when the district requested your consent for the initial evaluation describes protections under the IDEA. The Procedural Safeguards Notice is also available at https://www.michigan.gov/documents/mde/Procedural_Safeguards_Notice_550307_7.pdf.

The following sources are available to assist you in understanding your rights:

_____

_____.

X _____
Signature of Superintendent or Designee Date

PARENT CONSENT

☐ I give consent for the initial provision of special education programs and services.

☐ I refuse consent for the initial provision of special education programs and services.

X _____
Signature of Parent Date

DOCUMENTS FOR THE DISCLOSURE STUDENT INFORMATION
TO
MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES

_____ SCHOOL DISTRICT (the School District) currently provides necessary school-based health services to your child at no cost to you, the parent/guardian. The School District is participating in a Michigan Department of Health and Human Services program through which Federal Medicaid funds are made available to school districts in the State to help cover the costs of providing necessary school-based health services to students. By participating in this program, the School District is allowed to seek Federal Medicaid funds to help cover the costs of the health services the School District provides to your child. In order to seek the Federal funds, the School District must disclose information from your child's education records to Michigan Department of Health and Human Services. This may include personally identifiable information (ex. Name, Date of Birth) as well as records or information about the services that may be provided to your child.

The School District requests your consent to disclose information from your child's education records to Michigan Department of Health and Human Services as necessary for the School District to seek Medicaid funds to help cover the costs of the school-based health services the School District provided to your child. Whether or not you give your consent or if you withdraw your consent, the School District will continue to provide necessary health services to your child at no cost to you, the parent/guardian.

NOTIFICATION OF PARENT/GUARDIAN RIGHTS AND PROTECTIONS

To ensure that your child has access to a free appropriate public education, as required by Federal law, the School District must

- obtain your written consent prior to disclosing your child's health information to Michigan Department of Health and Human Services,
- may not require you to sign up for or enroll in any public benefits or insurance programs,
- may not require you to pay any out-of-pocket expenses such as a deductible or co-payment for the costs of the health services the School District provides to your child, and
- may not use your child's Medicaid or other public benefits if that use would.
    - decrease available lifetime coverage or any other insured benefit,
    - result in you or your family paying for services that would otherwise be covered by Medicaid or other public insurance program and that are required for your child outside of the time that your child is in school,
    - increase your insurance premiums or lead to the discontinuation of any public benefits or insurance, or
    - risk the loss of your eligibility for home and community-based waivers, based on aggregate health-related costs.

Giving your consent will cost you, the parent guardian, nothing, but will allow the School District to seek Federal financial support needed to better provide services to students. Whether or not you give your consent or if you withdraw your consent, the School District will continue to provide services to your child at no cost to you, the parent/guardian.

Please use the attached form to select your consent option.

PARENT/GUARDIAN CONSENT TO DISCLOSE STUDENT INFORMATION
TO
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

STUDENT'S NAME_____
(First) (Middle Initial) (Last)

STUDENT'S DATE OF BIRTH ___ ___/___ ___ / ___ ___

Please review the statements below and select your option by checking the appropriate box.

☐ Yes. As the parent/guardian of the student named above, I give my consent to the School District to disclose information from my child's education records to Michigan Department of Health and Human Services as necessary to allow the School District to seek Medicaid funds to help cover the costs of the school-based health services School District provided to my child.

I understand that my consent will remain in effect until I withdraw it, and that I may withdraw my consent at any time by notifying the School District. If I withdraw my consent, the School District will continue to provide necessary school-based health services to my child at no cost to me, the parent/guardian.

☐ No. As the parent/guardian of the student named above, I *do not* give my consent to the School District to disclose information from my child's education records to Michigan Department of Health and Human Services.

I understand that if I do not give my consent, the School District will continue to provide necessary school-based health services to my child at no cost to me, the parent/guardian.

Name: _____
(Name of parent/guardian)

Signature: _____ Date: _____
(Signature of parent /guardian) (Month-day-year)

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Intermediate School District

Fax: 906-863-7776

1201- 41st Avenue
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CONSENT FOR ACCESS/RELEASE OF INFORMATION

Student Name _____**Date of Birth** _____

Address_____

I hereby Authorize the release of information from:

(Doctor/Clinic/Hospital/Facility)_____

Address_____

Phone _____ **Fax** _____

To disclose information to:

Menominee County ISD
1201 41st Ave, Menominee, MI 49858
Phone : 906.863.5665, ext 1010 Fax: 906.863.7776

Information to be disclosed:

_____ Medical _____ Mental Health from date _____ to date _____

Information is requested for: _____ Educational Planning/Placement _____ Other

This authorization is voluntary. I can choose to revoke this consent at a later date, however the revocation must be in writing. If this consent is revoked, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that once my health/education information is used or disclosed pursuant to this authorization, it may no longer be protected by federal or state law, unless protected by Federal Regulations 42CFR Part 2 and the Public Act 258 in which case it cannot be re-disclosed by the Receiving Party without my written authorization. I understand the information may be released electronically. This agreement will expire one year from the date of signature, unless revoked in writing by the parent/guardian sooner.

Initial: _____ This is a two-way release to exchange information between parties identified above.

_____ _____
Signature of Parent/Legal Guardian (if student is a minor) Date

_____
Printed name of Parent/Legal Guardian (if student is a minor)

_____ _____
Witness Signature Date

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Dear Parent(s)/Guardian(s) of: _____

Therapy services in the schools are based on educational relevance and need as determined by the Individualized Education Planning Team (IEPT). A doctor's order is needed for school based services and, if your child becomes eligible for Medicaid, to bill Medicaid for these services.

Please sign this form and we will fax it to your physician. If you prefer to take this form to your physician, please have him/her fax a prescription to our office. This prescription is required to be renewed annually.

If you have any questions or concerns please contact the Special Education Director at 906-863-5665 x1012.

Thank you.

****

To: Dr. _____

RE: _____ Date of Birth: _____
Student Name

A prescription is needed for the following services:

_____ Speech/Language - Evaluation and/or treatment per educational goals

_____ Occupational Therapy - Evaluation and/or treatment per educational goals

_____ Physical Therapy - Evaluation and/or treatment per educational goals

_____ Orientation and Mobility - Evaluation and/or treatment per educational goals

_____ Personal Care Services (Please check all that apply)

☐Ambulation	☐Dressing	☐Personal Hygiene	☐Toileting
☐Mobility/Positioning	☐Grooming	☐Skin Care	☐Muscle Strengthening
☐Bathing	☐Respiratory Assistance	☐Eating/Feeding	☐Medical Equipment Maintenance
☐Transferring	☐Meal Preparation	☐Maintaining Continence	☐Health Related Functions through Hands On Assistance, Supervision and Cueing
☐Redirection and Intervention for Behavior	☐Intervention for Seizure Disorder	☐Assistance with Staff Administered Medications	

Please fax a prescription to the Menominee County ISD (Fax: 906-863-7776) as soon as possible

Parent Signature: _____

REVIEW OF EXISTING EVALUATION DATA (REED) AND EVALUATION PLAN
MENOMINEE COUNTY INTERMEDIATE SCHOOL DISTRICT

☐ Carney-Nadeau ☐ Stephenson ☐ Menominee ☐ North Central ☐ ISD

☐ Initial Evaluation ☐ Transfer-In ☐ Other: _____

Date of Referral:	Student's Name:		
Date of Birth:	Sex:	Grade:	UIC#:
Mother/Guardian:		Father/Guardian:	
Student's Primary Address:			
Mother Phone:		Father Phone:	
Parent Email:			

Participants: *Check the box ☐ next to the member who can interpret the instructional implications of evaluation results. Also check the box ☐ under each member's name to indicate how the member participated.*

_____
Student
☐ Phone ☐ Personal Communication ☐ In Person

_____
Parent/Guardian
☐ Phone ☐ Personal Communication ☐ In Person

_____
Parent/Guardian
☐ Phone ☐ Personal Communication ☐ In Person

_____
☐ Other
☐ Phone ☐ Personal Communication ☐ In Person

_____
☐ District Representative
☐ Phone ☐ Personal Communication ☐ In Person

_____
☐ General Education Teacher
☐ Phone ☐ Personal Communication ☐ In Person

_____
☐ Special Education Provider
☐ Phone ☐ Personal Communication ☐ In Person

_____
☐ Other
☐ Phone ☐ Personal Communication ☐ In Person

REVIEW OF EXISTING EVALUATION DATA		
Information	**Data Source**	**Description of Information**
Review of existing evaluations including current classroom-based, local, or state assessments.	DIBELS STAR M-STEP	
Review teacher and related service provider(s) observations.	Gen Ed Spec Ed Related Service	
Review evaluations and information provided by parents (outside medical reports).	Date of Report: _____ Source: _____	*Provide a copy of report.*
Interventions		
<u>*REQUIRED* Review of Input from Parent:</u>		

REVIEW OF EXISTING EVALUATION DATA (REED) AND EVALUATION PLAN

ADDITIONAL DATA NEEDED AND EVALUATION PLAN	
Assessment Area	**Data and Assessments Needed**
☐ Achievement	
☐ Adaptive Skills	
☐ Cognitive Ability	
☐ Social/Emotional/Behavior	
☐ Speech & Language	
☐ OT ☐ PT	
☐ Autism Evaluation	
☐ Other: _____	

☐ No testing is recommended at this time. Team recommends ongoing progress monitoring and data collection.

NOTICE OF SUFFICIENT DATA

☐ Based on the review of the data and input from the parent, it was determined that no additional data is needed to determine whether the student is or continues to be a student with a disability who has any special education and program needs. **State Reason (required):**

_____

If you, the parent, do not agree with this plan, you may request an evaluation. Contact Building Administrator.

CONSENT FOR ADDITIONAL ASSESSMENT

☐ Further testing is recommended at this time, as specified above, to determine whether the student is or continues to be a student with a disability who has any special education and program needs.

I, as parent/guardian,

1. Have received a copy of the Special Education Procedural Safeguards (the Procedural Safeguards Notice you received describes protections under the IDEA. The Procedural Safeguards Notice is also available at https://www.michigan.gov/documents/mde/Procedural_Safeguards_Notice_550307_7.pdf)
2. Understand the contents of this plan, and: **(Choose one)**

☐ I consent to the proposed evaluation plan

☐ I do NOT consent to the proposed evaluation plan (Explain concerns): _____

_____

_____ _____

Parent/Guardian Signature Date of Consent

_____ _____

Signature of Superintendent or Designee Date

If testing is recommended, the results of the evaluation identified in this plan will be reviewed at an IEP team meeting to be held on or before: _____

Send Completed Form to:

Menominee County ISD, 1201 – 41st Avenue, Menominee, MI 49858; Fax: 906-863-7776; Phone: 906-863-56650

Telephone: 906-863-5665

MENOMINEE COUNTY ISD
Intermediate School District

Fax: 906-863-7776

1201- 41st Avenue
Menominee MI 49858
Http://mc-isd.org

INVITATION TO ATTEND REVIEW OF EXISITING EVALUATION DATA (REED) MEETING

Dear: _____: Date: _____
Parent/Guardian/Surrogate/Student

A REED meeting has been scheduled for your child.

This meeting is scheduled for: _____
Student Name

_____at _____at _____
Date *Time* *Place*

If this time and/or place is not acceptable to you, please contact me as soon as possible by calling

_____.

Please feel free to invite any other persons of your choice to attend this meeting including individuals who you feel have knowledge or special expertise regarding your child. The school district has asked the following persons to participate in this meeting:

Participants	**Name and Position**
A representative of the public agency/adm. or designee	_____
Student	_____
The child's teacher(s)	_____
Member(s) of the multidisciplinary evaluation team	_____
	_____
Others	_____

_____ _____
Signature of Follow-up-contact Person *Date* *Name/Title*

Parental receipt of notice:

_____
Parent Signature *Date*