



SPECIAL EDUCATION SURROGATE PARENT PROGRAM

SPECIAL EDUCATION SURROGATE PARENT STUDENT REFERRAL FORM

Please complete in full. All information will be verified with the custodial agency prior to determination of eligibility. Additional information may be required.

1. STUDENT INFORMATION		Date: _____
Last Name:	First Name:	Middle Name:
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary	Date of Birth (mm-dd-yyyy):	Age:
Student's Race/Ethnicity Identification (check all that apply): <input type="checkbox"/> AA/Black <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-Race, Non-Hispanic <input type="checkbox"/> Unknown		
Current Residence (name and address of congregate care program)*:		
How long at this address?	Telephone Number:	
Name and title of contact person:	Email:	
*A REMINDER: For eligible children who are placed in foster homes, the foster parent may act as special education decision-maker upon placement. No appointment is necessary. Referrals should only be made to the SESP Program in limited circumstances. (See DCF Education Policy for Children Birth Through 22, App. B.)		

2. SCHOOL INFORMATION	
Current Educational Placement (name and address of school):	
How long at this school?	Telephone Number:
Name and Title of Contact Person:	Email:
School District(s) Responsible:	

3. SPECIAL EDUCATION STATUS (Select a or b & fill in the corresponding information. If neither applies, student is not eligible.)
<input type="checkbox"/> a. The student is currently receiving special education services. <input type="checkbox"/> Inclusion <input type="checkbox"/> Substantially Separate <input type="checkbox"/> Day School <input type="checkbox"/> Residential <input type="checkbox"/> Other (please specify): _____ Next Team Meeting date (mm-dd-yyyy):
<input type="checkbox"/> b. A request for an initial special education evaluation has been sent to the district.

4. CUSTODY STATUS (Select a or b & fill in the corresponding information. If neither applies, student is not eligible.)
a. The student is in the legal custody of DCF through: <input type="checkbox"/> Care and Protection (C&P) Proceedings <input type="checkbox"/> Legal Custody via Probate Court <input type="checkbox"/> 18+ and declared incompetent by the court (please attach a copy of the court documentation)
b. The student is NOT in the legal custody of DCF, but one of the following circumstances applies (additional documentation may be necessary): <input type="checkbox"/> A parent/guardian cannot be identified <input type="checkbox"/> A parent/guardian cannot be located <input type="checkbox"/> The student is an "Unaccompanied Homeless Youth" (McKinney-Vento 42 U.S.C §11434a(2) and (6))
<i>Students in DCF custody due to a Child Requiring Assistance (CRA), a Voluntary, or a Care and Responsibility (C&R) are not eligible for an SESP unless the parent/guardian is unidentifiable or unable to be located. Neither a parent's lack of expertise in Special Education nor lack of fluency in English is a basis for an SESP Appointment.</i>

5. Family member or other adult (i.e. GAL, Visiting Resource, prior foster parent) may be willing to be appointed as SESP for this student*:

☐ **Yes** (please complete information below) ☐ **No**

Last Name:

First Name:

Address (Street, City, State and Zip):

Telephone Number:

Email:

Relationship to Child*:

****If DCF has legal custody but has determined that the parent/guardian can act as special education decision-maker, no referral to the SESP Program is necessary.***

6. CHILD'S SOCIAL WORKER

Name:

Telephone Number:

Cell Number:

Agency:

Email:

Address (Street, City, State and Zip):

Supervisor's Name:

Telephone Number:

Cell Number:

Email:

7. REFERRAL SUBMITTED BY: (Complete only if other than the Social Worker)

Name:

Title:

Agency:

Telephone Number:

Cell Number:

Address (Street, City, State and Zip):

Email:

Signature of person completing referral:

**Please type full name and title if sending electronically. This will serve as your electronic signature.*

An SESP's responsibility and authority is to make decisions regarding a child's special education services and placement. Consistent with these responsibilities, SESP's have the right to access all regular and special education records of the student. Additional information and records unrelated to the student's special education program may be shared as necessary by the Department of Children and Families or other custodial state agency. Please contact the SESP Program at 508-792-7679 or visit www.sespprogram.org for more information on the rights and responsibilities of the SESP.

Did you –

- ☐ Notify the student's attorney, Family Networks education coordinator, and the school district that a referral has been made to the SESP Program?
- ☐ Attach a list of all persons to be notified of the SESP appointment?

Send to: Special Education Surrogate Parent Program

P.O. Box 1184

Westboro, MA 01581

Ph: 508-792-7679 ~ Fax: 508-616-0318 ~ contactus@sespprogram.org