

REFERRAL TO THE COMMITTEE ON PRESCHOOL SPECIAL EDUCATION

This form is to be used by professional staff members to refer a preschool age child (ages three [3] or four [4]) suspected of having an educational disability to the Committee on Preschool Special Education for a multidisciplinary assessment and possible recommendation for special education services.

It is strongly advised that this form be completed in its entirety; indicate N/A in those sections not applicable. Be sure to write legibly. Attach to this form any documentation relevant to this referral.

SECTION I: REASON FOR REFERRAL

SECTION II: DEMOGRAPHIC DATA

Home District CPSE# _____ NYC ID # If known: _____

Child's Name _____ / / .
Last First M. D.O.B.

Home Address _____ Apt. # _____ Borough _____ Zip Code _____

Name of Parent/Guardian _____

Home Language(s) _____ Child's Language(s) _____ Parent's Preferred Language(s) _____

Home Tel.#/Bus. Tel.# _____ Emergency Contact _____ Emergency Phone # _____

SECTION III: REFERRAL INFORMATION (place an "X" in the appropriate box)

- A parent/legal guardian or person in parental relationship
- A licensed physician or other health professional.
- The Commissioner or designee or a public agency with responsibility for welfare, health or education for children.
- A judicial officer
- An Early Childhood Direction Center (ECDC)
- Universal Pre-K Program
- NYC Early Intervention Program (EIP)
- Other please specify: _____

Referral Source Name _____ Telephone # _____

Address _____

Borough _____ Zip Code _____

Foster Care Agency _____ Telephone # _____

Contact Person If Different From Referral Source _____ Telephone # _____

Address _____ Borough _____ Zip Code _____

Is child or family known to any state, city, private agency or clinic? Yes No

If yes, indicate agency/clinic name: _____

Address _____ Borough _____ Zip Code _____

Contact Person _____ Telephone # _____

Reason for agency involvement: _____

If multiple agencies are involved with child/family, indicate other agency affiliations:

SECTION IV: DEVELOPMENTAL HISTORY

Indicate any pre/post natal complications experienced: _____

"X" ALL APPLICABLE CATEGORIES UP TO THE CHILD'S CURRENT AGE

- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <u>0 - 6 mos.</u> | | <u>7 - 12 mos.</u> | |
| Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | reaches/grasps | | sits & pulls to stand |
| | vocalizes | | says "Mama-Dada" |
| | smiles | | plays patty cake |
| | turns to sound | | pincer grasp |
|
<u>1 -3 years</u> | |
<u>3 - 5 years</u> | |
| Yes | No | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | runs well | | jumps in place |
| | speaks clearly | | tells a story |
| | imitates actions | | knows first & last name |
| | uses crayon | | plays well with others |

Does the child exhibit any of the following behavior(s)?

"X" ALL APPROPRIATE CATEGORIES

- | | | | |
|--------------------------|---------------------------------|--------------------------|---|
| <input type="checkbox"/> | Shows initiative | <input type="checkbox"/> | Fearfulness |
| <input type="checkbox"/> | Persistence on tasks | <input type="checkbox"/> | Destructiveness of property |
| <input type="checkbox"/> | Cooperative and helpful | <input type="checkbox"/> | Frequent crying |
| <input type="checkbox"/> | Self-abusive behavior | <input type="checkbox"/> | Physical abusiveness |
| <input type="checkbox"/> | Resistance to follow directions | <input type="checkbox"/> | Little or no responsiveness to organized activities |
| <input type="checkbox"/> | Verbal abusiveness | | |

SECTION V: PHYSICAL DEVELOPMENT/MEDICAL BACKGROUND

Complete the following section(s) based upon personal knowledge, observation, and/or available documentation.

General Health/Vitality _____
 Vision (Including screening) _____
 Hearing (Including screening) _____
 Oromotor _____
 Feeding _____
 Coordination _____
 Mobility _____
 Seizures _____

Does the child wear glasses, hearing and/or any other prosthetic device(s)? Describe:

Does the child wear diapers? Yes No
 Is the child currently receiving medication? Yes No If yes, indicate its name, dosage and purpose:

Does the child have any allergies? Yes No
 If yes, describe: _____

Has the child sustained any injuries, physical trauma? Yes No
 If yes, describe: _____

Has the child every been hospitalized? Yes No
 If yes, describe: _____

SECTION VI: SOCIAL INTERACTION/SOCIALIZATION

Indicate the child's response(s) to management approaches. "X" all applicable categories:

- | | |
|---|--|
| <p>a) <u>Child works well:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> on one-to-one basis <input type="checkbox"/> in small groups <input type="checkbox"/> in large groups <input type="checkbox"/> independently <input type="checkbox"/> during adult directed activity <input type="checkbox"/> during play/recreational activity <input type="checkbox"/> during quiet time <input type="checkbox"/> during lunch | <p>b) <u>Child interacts well with:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> peers <input type="checkbox"/> younger children <input type="checkbox"/> adults <p>c) <u>Child responds well to:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> praise <input type="checkbox"/> punishment <input type="checkbox"/> positive reinforcement <input type="checkbox"/> parent contact |
|---|--|

SECTION VII: EDUCATIONAL BACKGROUND

Indicate whether the child is demonstrating excellent (E); satisfactory (S); or poor (P) performance in any of the areas listed below:

- | | |
|--|--|
| <p style="text-align: center;"><u>READING</u></p> <p>___ identifying letters of the alphabet</p> <p>___ identifying shapes</p> <p>___ keeping place on page</p> <p>___ sequencing events</p> | <p style="text-align: center;"><u>MATHEMATICS</u></p> <p>___ identifying shapes</p> <p>___ counting & identifying numerals</p> <p>___ understanding time concepts</p> <p>___ understanding concepts such as less than, greater than, etc.</p> <p>___ remembering signs & symbols</p> |
|--|--|

SELF HELP SKILLS

- ___ toilets him/herself
- ___ buttons
- ___ zippers
- ___ feeds him/herself

Specify any other pertinent areas of performance. For children transitioning from EI please specify current performance levels.

SECTION VIII: SPEECH AND LANGUAGE

"X" area student has significant difficulty with and specify the language in which such difficulty is demonstrated:

- | | |
|---|-----------------|
| <input type="checkbox"/> articulation | Language: _____ |
| <input type="checkbox"/> expressing him/herself orally | _____ |
| <input type="checkbox"/> using age appropriate language | _____ |
| <input type="checkbox"/> understanding what is said | _____ |
| <input type="checkbox"/> speaking whole sentences | _____ |

Specify any other pertinent areas:

Is child's general knowledge appropriate to his/her peer grouping? Yes No

If no, describe:

For the reasons indicated on this referral form, I believe this child requires an evaluation to determine an educational disability and preschool special education service(s).

Print Name of Referring Person

Title/Relationship

Signature of Referring Person

Date

NOTICE OF REFERRAL (INITIAL)

Date: _____

Student's Name: _____

CSE Case #: _____

Home Address: _____

NYC Student ID#: _____

Date of Birth: _____

Dear Parent/Guardian:

The Committee on Preschool Special Education has received a referral from

(name/title _____), (school/agency _____)

requesting an evaluation of your child _____
First Name Last Name

to determine his/her educational needs and whether special education services are necessary.

It will be necessary to evaluate your child to determine if he/she has an educational disability. This evaluation will include a social history intake, psychological evaluation and any other appropriate evaluations that may be necessary to determine your child's educational needs. You may be asked to give us a Physical Examination report on your child, which will be considered during the evaluation. A Request for a Physical Examination Form, attached to this letter, should be completed by your doctor. If you do not have a physical examination, the State approved evaluation site will assist you to obtain one.

We need your written consent, prior to conducting any evaluations. The evaluation must be conducted by a New York State Education Department approved preschool evaluation site which you select. A listing of evaluation sites is included for your use. If you require assistance in selecting an evaluation site, please telephone me at (_____) _____, or you may call one of the Early Childhood Direction Centers (ECDC) listed below:

ECDC/Brooklyn
160 Lawrence Avenue
Brooklyn, NY 11230
(718) 437-3794

ECDC/Manhattan
435 East 70th Street - Suite 2A
New York, NY 10021
(718) 746-6175

ECDC/Queens
82-25 164th Street
Jamaica, NY 11432
(718) 380-3000 ext. 465

ECDC/Staten Island
1034 Targee Street – Room 107
Staten Island, NY 10304
718) 390-4737

ECDC/Bronx
2488 Grand Concourse, Suite 405
Bronx, NY 10458
(718) 584-0658

Once you have selected an evaluation site, you must contact the site to request an appointment to have your child evaluated. When you meet with a representative of the evaluation site, s/he will explain the purpose of the evaluation and your rights under the law. If your child is recommended to receive preschool special education service(s), you must provide a record of immunizations before your child will be admitted into a program.

The law provides you with certain rights, including procedural safeguards, in connection with this referral. Your Notice of Rights as a Parent of a Child with a Disability are attached.

Also, enclosed is a Consent for Initial Preschool Evaluation (C-1P) letter which YOU MUST BRING TO THE EVALUATION SITE that you select. Your written consent is needed for the evaluation site to conduct the evaluation of your child. If, within fifteen (15) days from the date of this letter we do not hear from you, we will contact you to discuss your child's referral. If you have any questions, please call:

_____ at _____.
contact person telephone number

The law provides you with certain rights, including procedural safeguards, in connection with this referral. Your Notice of Rights as a Parent of a Child with a Disability are attached.

Sincerely,

Chairperson, Committee on Preschool Special Education # _____

- Attachments: Listing of State Education Department Approved Evaluation Sites
Notice of Parental Rights
Consent for Initial Preschool Evaluation
Request for Physical Examination

CPSE LETTERHEAD

NAME OF CHILD: _____ **CSE CASE #:** _____
DATE OF BIRTH: _____ **NYC ID #:** _____
HOME ADDRESS: _____ **DATE ISSUED:** _____

CONSENT FOR INITIAL EVALUATION

Date: _____

To Whom It May Concern:

I give my consent to have my child evaluated to determine if he/she has an educational disability and is eligible for special education services. I understand that the assessment process may include a social history, psychological evaluation, physical examination and any other appropriate evaluations that may be necessary to determine my child's educational needs.

The nature and purpose of each of these evaluations has been explained to me and I understand that I may withdraw my consent in writing at any time prior to development of the Individualized Education Program (IEP).

I also consent to have my child's records released to appropriate public or private educational agencies and schools for the purpose of determining an appropriate educational placement.

I have received a copy of the New York State Education Department Procedural Safeguards Notice. My due process rights have been explained to me. I understand that I will be invited to participate in all future planning meetings regarding the education of my child.

I have selected the following New York State approved evaluation site to conduct an evaluation of my child:

Name of Site: _____ **Telephone #:** _____

NYC Code # (to be completed by evaluation site) _____

Address: _____

Zip Code: _____

Scheduled Date of Evaluation: _____

DO NOT SIGN THIS LETTER UNTIL YOU UNDERSTAND YOUR LEGAL RIGHTS, HAVE MET WITH A REPRESENTATIVE FROM THE EVALUATION SITE OF YOUR CHOICE OR THE COMMITTEE ON PRESCHOOL SPECIAL EDUCATION AND YOU AGREE TO HAVE YOUR CHILD EVALUATED.

⇒ SIGNATURE OF PARENT/GUARDIAN _____ **DATE:** _____



THE NEW YORK CITY DEPARTMENT OF EDUCATION

JOEL I. KLEIN, *Chancellor*

SCHOOL PROGRAMS & SUPPORT SERVICES
52 Chambers Street, Room 220 · New York, NY 10007

REQUEST FOR PHYSICAL EXAMINATION

Dear Parent Guardian:

Date Letter Sent: _____

As part of the evaluation process for special education services, the New York State Education Department approved evaluation site you select must provide or review a current physical examination. Please have your doctor/clinic complete and return the form to:

Name: _____ Title: _____ Telephone: _____

Evaluation Site: _____

Address: _____

If you need help in obtaining a physical examination, staff from the evaluation site will assist you. Please note that your signed consent for release of these records is attached.

Name of the Child: Last: _____ First: _____

School: _____ Date of Birth: _____

CSE Case #: _____ NYC Student ID#: _____

THIS SECTION TO BE COMPLETED BY DOCTOR/HEALTH CARE PROVIDER/CLINIC

Has the student had or now have any of the following:

- ADHD
- Asthma
- Autism
- Allergies List _____
- Blood Disorders
- Cancer
- Diabetes
- Congenital Heart Disease
- Hearing Problem
- Neurological Disorder
- Orthopedic Problem
- Seizures (Type) _____
- Shunt
- Speech Problem
- Tuberculosis
- Vision Problem
- Other: _____

If you have checked off any of the above boxes, please give a brief history

	Reason	Date	Place
<input type="checkbox"/> Hospitalizations	_____	_____	_____
<input type="checkbox"/> Surgery (what kind)	_____	_____	_____
<input type="checkbox"/> Serious illnesses	_____	_____	_____
<input type="checkbox"/> Serious Accidents	_____	_____	_____
<input type="checkbox"/> Other Problems or Limitations	_____	_____	_____

If you have checked any of the above boxes, please give a brief history

PHYSICAL EXAMINATION Height : _____ (_____ %) Weight: _____ Blood Pressure: _____
GENERAL APPEARANCE (NUTRITIONAL STATUS/SPECIAL DIET): _____

- | | | | | | | | |
|--------------------------|--|--------------------------|---|--------------------------|--------------------------------------|--------------------------|--------------------------------------|
| NL | AB | NL | AB | NL | AB | NL | AB |
| <input type="checkbox"/> | <input type="checkbox"/> Heent | <input type="checkbox"/> | <input type="checkbox"/> Lungs | <input type="checkbox"/> | <input type="checkbox"/> Extremities | <input type="checkbox"/> | <input type="checkbox"/> Language |
| <input type="checkbox"/> | <input type="checkbox"/> Dental status | <input type="checkbox"/> | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> | <input type="checkbox"/> Back | <input type="checkbox"/> | <input type="checkbox"/> Gross Motor |
| <input type="checkbox"/> | <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> Abdomen | <input type="checkbox"/> | <input type="checkbox"/> Skin | <input type="checkbox"/> | <input type="checkbox"/> Fine Motor |
| <input type="checkbox"/> | <input type="checkbox"/> Lymph | <input type="checkbox"/> | <input type="checkbox"/> Genito Urinary | <input type="checkbox"/> | <input type="checkbox"/> Neuro | | |

DESCRIBE ABNORMALITIES:

REQUEST FOR PHYSICAL EXAMINATION

Name of Child: Last: _____ First: _____

SCREENING TESTS:	DATE	RESULTS	DATE	RESULTS	VISION DATE	RESULTS
Hematocrit/Hemoglobin	_____	_____	Urinalysis	_____	Far	_____
HGB Electrophoresis	_____	_____	Audio Sweep	_____	Near	_____
Scoliosis	_____	_____	Threshold	_____	Fusion	_____
Sickle Cell Anemia	_____	_____	Medical red for FM Unit	YES <input type="checkbox"/> NO <input type="checkbox"/>	Color	_____

LEAD:

FED _____ ZNP _____ More Lead _____ Venous Lead _____
 Date (Results) Date (Results) Date (Results) Date (Results)

TB: MANTOUX	DATE	RESULTS	DATE	RESULTS
(PPD) Implanted	_____	<input type="checkbox"/> Negative MM	CHEST X-RAY	_____
READ	_____	<input type="checkbox"/> Positive MM		
BGG VACCINE	_____	YES <input type="checkbox"/>	<input type="checkbox"/> NO	TREATMENT PLAN: _____
			MEDICATION START DATE: _____	D/C DATE: _____

IMMUNIZATION – DATES

DPT or DT or TD	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MEASLES	___/___/___	___/___/___
Poho (TOPV) Sabin	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MUMPS	___/___/___	___/___/___
IPV (SolK)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	RUBELLA	___/___/___	___/___/___
HIB	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MR	___/___/___	___/___/___
HEP B STATUS	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___

DIAGNOSIS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICATION/TREATMENT TO BE ADMINISTERED IN SCHOOL ONLY:

Name of Medication: _____ Dosage: _____ Route: _____
 PRN order? (If so, under what conditions should medication be given?) _____

Indicate any medically provided treatment required in school (e.g. , tracheostomy care, catheterization G-tube feeding etc.) _____

Indicate specific instructions for providing treatment: _____

Frequency/time to be provided: _____

Conditions under which treatment should be provided: _____

Conditions under which treatment should not be provided: _____

Possible side effects/adverse reactions to treatment: _____

RECOMMENDATIONS:

- Regular Physical Education No Physical Education
 No Competitive Sports Restrictions (specify) _____

OT/PT SPEECH THERAPY

(Please complete for OT/PT Speech Therapy if necessary)

I am referring the student for an evaluation for the service(s) and for the provision of: _____ if it is
 determined to be appropriate as result of such evaluation. Fill in type of service(s)

Physician Name: (Please print) _____ Date of Exam: _____

Name of Facility: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Physician's Signature: _____ License #: _____

CPSE LETTERHEAD

WITHDRAWAL NOTIFICATION

CHILD'S NAME: _____
 NYC ID #: _____
 DATE OF BIRTH: _____
 HOME ADDRESS: _____

 DATE: _____

Dear Parent/Guardian:

SECTION 1 WITHDRAWAL OF REFERRAL PRIOR TO SELECTION OF AN EVALUATION SITE

[1] Recently, your child was referred for evaluation to determine if there was a need for special education services or a modification in his/her Individualized Education Program (IEP). As of this time, you have either not responded or you have refused to consent to the evaluation. Therefore, we will withdraw the referral at this time.

SECTION 2 WITHDRAWAL OF REFERRAL AFTER SELECTION OF AN EVALUATION SITE

- [2] You have not attended the scheduled evaluation site meetings and/or have not responded to our outreach attempts.
- [3] You have informed us in writing that you wish to withdraw your consent to have your child evaluated.
- [4] The evaluation of your child commenced and was or was not completed. Prior to IEP review you informed us in writing your wish to withdraw from the Committee on Preschool Special Education (CPSE) process.

Therefore, we will withdraw the referral at this time. However, you may request that we proceed with your child's evaluation at a later date by writing to the Committee on Preschool Special Education.

SECTION 3 WITHDRAWAL OF PLACEMENT NOTICE

[5] On (date of referral _____) the Committee on Preschool Special Education (CPSE) sent you a letter which notified you that your child was recommended to receive special education services. We have attempted to obtain your consent to our recommendation. As of this time, however, you have either not responded or you have refused to consent to the recommended services.

If we do not hear from you by (date _____), this offer of placement will have to be withdrawn. However, your child will be referred to the Committee on Special Education as a child suspected of having an educational disability when s/he is turning five.

[6] The Committee on Preschool Special Education conducted a meeting to discuss the educational needs of your child and recommended a special education program/service(s). Your consent for provision of the recommended program/service(s) has been obtained.

It has come to our attention that your child is not attending/receiving the recommended special education program/service(s). Therefore, we are withdrawing your child from the recommended placement. However, you may request that we re-open the case of CPSE at a later date. Please be advised the current service provider may no longer be available at that time.

The law provides you with certain rights, including procedural safeguards, in connection with this evaluation. The New York State Education Department Procedural Safeguards Notice is attached. If you have any questions or you wish to reconsider the evaluation/placement of your child, we would be happy to talk with you. Please telephone _____ at (____)_____ or write to us at the above address to request a meeting.

You may re-open the case at any time by contracting us in writing.

Sincerely,

 Committee on Preschool Special Education

Attachment: New York State Education Department Procedural Safeguards Notice
 c: Evaluation Site: _____ (as appropriate)

Preschool Service Provider: _____ (as appropriate)

CPSE LETTERHEAD

NOTIFICATION OF REQUEST FOR A REVIEW OF AN IEP AND CONSENT FOR REEVALUATION

Date: _____

Dear Parent/Guardian:

The Committee on Preschool Special Education has received a referral requesting a review of your child's current IEP.

1 After a review of current information, it has been determined that additional assessments are required as part of this request. The assessment process may include a social history intake (update), psychological evaluation, a speech/language evaluation and any other appropriate evaluations that may be necessary to determine your child's continued educational needs.

The nature and purpose of each of these examinations is to provide important information about whether or not your child continues to have an educational disability, the continued need for special education and related services, present levels of performance, and if modifications are necessary to your child's Individualized Education Program (IEP) to meet annual goals.

If you want any specific assessments to be administered, please let us know immediately.

It is very important that you sign this consent form if new assessments are required and return it to the evaluation site you select from the list of New York State Education Department Approved Preschool Evaluation Sites.

If you do not select an evaluation site by _____, we will attempt to contact you by telephone. If you do not reply, the CPSE will arrange for the necessary evaluations to be conducted without written consent. You will be invited to participate in all future planning meetings regarding the education of your child.

OR

2 It has been determined that no additional assessments are required. However, you have the right to ask that new assessment be administered. If reassessments are not required you do not need to sign this form.

If you have any private evaluation material which may assist the Committee on Preschool Special Education, please send or bring the information to the evaluation site or forward it to the CPSE at the address in the letterhead.

The law provides you with certain rights, including procedural safeguards, in connection with this review. The New York State Education Department Procedural Safeguards Notice is attached.

Sincerely,

CPSE Chairperson

Attachment: New York State Education Department Procedural Safeguards Notice

IMPORTANT!! – Please Sign and Return this Notice to the New York State Education Department Approved Preschool Evaluation Site only if box one (1) above was marketed with an "X".

I give consent for new tests and assessments to be given to my child, named below, as described for the purposes of a requested or annual review.

⇒ SIGNATURE OF PARENT/GUARDIAN _____ DATE: _____

Child's Name: _____ Preschool Provider: _____

NYC ID#: _____ DOB: _____

CSE Case #: _____ Date: _____

Home Address: _____

EVALUATION SITE LETTERHEAD**HOME LANGUAGE SURVEY**

NAME OF CHILD: _____ DATE OF BIRTH: _____

SCHOOL: _____ GRADE OR LEVEL: _____

Name of Person Completing the Survey: _____

DIRECTIONS: If any one answer indicates that the child's first language is other than English, then the multidisciplinary assessment must include the first language.

PLEASE ANSWER THESE QUESTIONS CONCERNING THE CHILD:

1. What is your relationship to the child? (Check one)
 Mother
 Father
 Guardian
2. What language did your child learn when he/she first began to talk?
3. What language does your family speak in your home most of the time?
4. What language does the mother speak to her child most of the time?
5. What language does the father speak to his child most of the time?
6. What language does the child speak to his/her mother most of the time?
7. What language does the child speak to his/her father most of the time?
8. What language does the child speak to other adults at home most of the time?
9. What language does your child speak to his/her brothers and sisters most of the time?
10. What language does your child speak to his/her friends most of the time?

Signature_____
Date

* Instructional decisions will not be based solely on the information provided in the survey.

EVALUATION SITE LETTERHEAD
OR
CPSE LETTERHEAD

DATE: _____

Dear Parent/Guardian:

An appointment has been arranged for you to meet with us on _____,
(Date)
_____ at _____ in order to explain the
(Time) (Evaluation Site/Address)
evaluation process and secure your consent to conduct the evaluations. Please bring with you the original consent letter sent or given to you by the Committee on Preschool Special Education (CPSE). You may also bring other individuals who have knowledge or special expertise regarding your child to this meeting. You may submit any reports, evaluation or other written information regarding your child that you want to share with the CPSE.

The law provides you with certain rights, including procedural safeguards, in connection with this review. The New York State Education Department Procedural Safeguards Notice is attached.

If you have a disability, which may require special arrangements, or if you need a translator or an interpreter for the deaf, please telephone _____ at
() _____.

If you have any questions or if this meeting is not convenient for you, immediately telephone the person listed above.

Sincerely,

Evaluation Site Representative
or
Committee on Preschool Special Education

c: CPSE # _____, Chairperson

Child's Name: _____ **NYC ID#:** _____

DOB: _____

Home Address: _____

EVALUATION SITE LETTERHEAD

EVALUATION SITE NOTIFICATION TO PARENT FORM

Dear Parent or Legal Guardian,

On ____ / ____ / ____ you selected the _____ as the State approved evaluation site for your child. At this time, staff is unable to complete the evaluation of your child within mandated timelines.

We anticipate that we should be able to complete all appropriate evaluations for your child by approximately ____ / ____ / _____. If you still wish to have this agency complete the evaluations, please enter a check in box **1** below and sign this form. If you wish to select another evaluation site, please enter a check in box **2** below and sign your name. You may then select another evaluation site or contact the Committee on Preschool Special Education (CPSE) for additional assistance.

The signed copy of this document will be sent to the CPSE.

If you have any questions, please contact _____ at (____) _____.

Sincerely,

_____ Date

1 I agree to have my child evaluated at your agency by the date indicated above.

⇒ SIGNATURE OF PARENT/GUARDIAN _____ DATE: _____

2 I wish to select another evaluation site for my child.

⇒ SIGNATURE OF PARENT/GUARDIAN _____ DATE: _____

c: Committee on Preschool Special Education District #: _____

EVALUATION SITE LETTERHEAD

NOTIFICATION OF FAILURE TO ATTEND AN EVALUATION SITE MEETING

DATE: _____

Dear Parent/Guardian:

You were scheduled to attend a meeting regarding your child at this evaluation site.

- Although we have made several attempts to contact you, we have not heard from you. Therefore, we are requesting that the Committee on Preschool Special Education (CPSE) use appropriate outreach to determine if you are interested in continuing the preschool evaluation process prior to the CPSE withdrawing the referral.
- You have indicated in writing that you are no longer interested in having your child evaluated for preschool services. The CPSE will contact you to confirm your decision.

If you have any questions, or you wish to continue the evaluation process, we would be happy to talk to you. Please telephone _____

at (_____) _____ or write to us at the above address.

Sincerely,

Evaluation Site Representative

c: CPSE # _____, Chairperson

Child's Name: _____ **NYC ID#:** _____

DOB: _____

Home Address: _____

PRESCHOOL STUDENT EVALUATION SUMMARY REPORT

Student's Name:	Date of Birth:	Date of Evaluation:
Parent/Guardian:	Relationship:	Agency:
Address:	Contact Person:	Phone:
County of Residence:	School District:	

This reporting form provides a summary of the findings of the evaluation which includes a detailed statement of the child's individual needs. As a result of Chapter 474 of the Laws of 1996, the evaluator may no longer recommend the general type, frequency and duration of special services and programs needed nor address the manner in which the special services and programs can be provided in the least restrictive environment.

Please indicate the individually administered evaluation measures used, including the result of the observation of the child and the findings pertinent to the following domains. Incorporate the strengths of the child and the characteristics relating to the suspected disability. This summary and the documentation of the evaluation results are to be transmitted to all the members of the Committee on Preschool Education (CPSE) and to the Municipality Representative. Before meeting with the parent, the CPSE must transmit a copy of this evaluation summary report to the parent. The summary report must be transmitted in English, and when necessary, in the dominant language or other mode of communication of the parent.

1. Cognitive
2. Social/Emotional
3. Motor Development

4. Language and Communicative

5. Adaptive/Functional Behavioral Assessment

Please indicate the date the evaluation results, including this summary report, were sent to the Committee on Preschool Special Education and the Municipality Representative:_____.

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STAC ID

Request for Commissioner's Approval of Reimbursement for the Cost of Evaluations

Please Print Clearly

1. NAME OF CHILD (Last) (First) (M.I.)

2. DATE OF BIRTH 3. GENDER 4. SOCIAL SECURITY NUMBER

Month / Day / Year Male Female 5. SIS CHILD ID NUMBER

6. Racial/Ethnic Category of Child (Definitions on the reverse side of this form)

Amer. Indian or Alaskan Native Asian or Pacific Islander Black Hispanic White

7. The child named above is:

PD - Preschool Student With a Disability ND - Non-Disabled

8a. School District with CPSE Responsibility

--	--	--	--	--	--	--	--	--	--

b. County of Child's Current Location (where child resides)

--	--	--	--	--	--	--	--	--	--

c. County at time of Placement in Foster Care

--	--	--	--	--	--	--	--	--	--

9. Approved Evaluator

--	--	--	--	--	--	--	--	--	--

12. CERTIFICATION OF EVALUATION: I certify that the preschool child herein named received a multidisciplinary evaluation as indicated above and in accordance with Section 4410 of the Education Law and the Regulations of the Commissioner of Education.

Signature CPSE Chairperson _____ Date _____ CPSE Review Date (if different) _____

13. MUNICIPALITY SIGNATURE SECTION:

The municipality of _____ has received on _____ / _____ / _____ the STAC-5 Request for Commissioner's Approval of Reimbursement for the Cost of Evaluations for the above named child pursuant to Section 4410 of the Education Law.

Signature of Authorized Representative of the Municipality _____ Date _____

10. List the date each evaluation component was completed (use four digits to indicate month and year). For bilingual evaluations indicate on line provided.

EVALUATION COMPONENT	Month / Year	Check if Bilingual
Physical/Medical	PHY / /	
Social	SOC / /	
Psychological	PSY / /	
Audiological	AUD / /	
Education	EDU / /	
Neurological	NEU / /	
Neuropsychological	NPY / /	
Occupational Therapy	OCT / /	
Optometric (visual)	OPT / /	
Orthopedic	ORT / /	
Otolaryngology	OTO / /	
Physical Therapy	PHT / /	
Psychiatric	PYC / /	
Speech / Language	SPT / /	

11. Cost of translation/transmittal of evaluation documentation or summary report for monolingual evaluations only. \$ _____

PLEASE PRINT THE NAME AND ADDRESS OF THE PERSON COMPLETING THIS FORM IN THE SPACE PROVIDED ON THE BACK OF THE ORIGINAL

CPSE LETTERHEAD
MEETING NOTICE FOR CPSE REVIEW

Date: _____

Dear Parent/Guardian:

Now that the evaluations of your child have been completed an IEP meeting has been scheduled to discuss the results. It is very important for you to attend this meeting. We will be determining whether your child has an educational disability, or continues to have a disability, which requires special education services and the development of an Individualized Education Program (IEP). The people listed below have been invited to participate:

Title/Agency/Name

- CPSE Chairperson/Designee: _____
- Individual Knowledgeable About the Evaluation Procedures: _____
- Early Intervention Provider (as appropriate): _____
- Special Education Teacher: _____
- Parent Member: _____
- General Education Teacher: _____
- Other: _____

It is your right to participate fully in this decision-making process. You may bring other individuals who have knowledge or special expertise regarding your child. If you have a disability which may require special arrangements, or if you need a translator or interpreter for the deaf, please contact the CPSE.

Copies of all evaluation reports and an evaluation summary should have been provided to you by the evaluation site. Please let me know if you have not received them. You may send or bring any additional information with you to the IEP meeting.

An appointment has been scheduled for you to meet with us on:

DATE: _____ **TIME:** _____

ADDRESS: _____

You have the right to decline the participation of the parent member at the CSE Review meeting. The parent member serves as an advocate and provides information to you throughout the IEP meeting. Should you wish to decline the participation of the parent member, please sign the attached form indicating this request.

You have the right to request that a physician member of the Committee on Preschool Special Education and/or a member of the evaluation team attend. However, you must notify the contact person listed above at least seventy-two (72) hours prior to the meeting date if you wish to arrange this.

If you are unable to attend this meeting, please call me immediately to arrange an alternate date/time. If you are unable to attend a meeting at all, you may telephone me to arrange for a telephone conference.

If we do not hear from you or you are unable to attend, the meeting will occur as scheduled. You will receive either a copy of the program recommendation or a notice to attend another meeting with the Committee on Preschool Special Education to review your child's records to determine the appropriate educational services. The law provides you with certain rights, including procedural safeguards, in connection with this meeting. The New York State Education Department Procedural Safeguards Notice is attached.

Sincerely,

Committee on Preschool Special Education

Attachments:
New York State Education Department Procedural Safeguards Notice

- c: School or Service Provider (as appropriate) (without attachments)
- All Invited Persons Listed Above (without attachments)
- Other(s): _____ (without attachments)

Child's Name: _____ **CSE Case #:** _____

NYC ID#: _____ **DOB:** _____

Home Address: _____

CPSE LETTERHEAD

AWAITING PLACEMENT NOTIFICATION

DATE: _____

Dear Parent/Guardian:

The Committee on Preschool Special Education has determined that your child is a preschool student with a disability and believes that a special education service(s) may be warranted.

At this time, we cannot finalize the recommendation for service(s) for the following reason(s):

We will notify you in writing when the service(s) becomes available and arrange a meeting with the Committee to complete the Individualized Education Program (IEP).

Sincerely,

Committee on Preschool Special Education

Child's Name: _____ NYC ID#: _____

DOB: _____

Home Address: _____

CPSE LETTERHEAD

PSN

NOTICE OF ELIGIBILITY FOR PARTIAL SERVICES

Student's Name: _____ **NYC Identification #:** _____

CPSE #: _____ **Date:** _____

Dear Parent/Legal Guardian:

On _____ the Committee on Preschool Special Education (CPSE) conducted a meeting to review your son/daughter's educational needs and eligibility for special education services. At that time your child was determined to have an educational disability and was recommended to receive the following services:

Including the Following Related Services

Program Recommendation (Check one)

(if applicable)

<input type="checkbox"/> Special Class (full day) _____
<input type="checkbox"/> Special Class (half day) _____
<input type="checkbox"/> Special Class in an Integrated setting (full day) _____
<input type="checkbox"/> Special Class in an Integrated setting (half day) _____
<input type="checkbox"/> Special Education Itinerant Teacher services (SEIT) _____

At this time we are unable to identify a preschool where your child can receive all of the special education services listed on his/her Individualized Education Program (IEP). We are, however, able to offer the services (listed below):

<u>Partial Service(s) That Can be Provided</u>	<u>Frequency/Duration Group Size (For SEIT or Related Services)</u>	<u>Provided by/Location</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

We will continue our efforts to identify a preschool setting where your child will be able to receive the special education services recommended on the IEP. When an appropriate preschool setting has been identified, you will be invited to an IEP meeting. Your child will be eligible to receive partial services by the providers specified above until that time. Please contact me at (_____) _____ if you have any questions.

The law provides you with certain rights, including procedural safeguards. Please refer to the New York State Education Department Procedural Safeguards Notice or the Parent's Guide for Special Education in New York State for Children 3-21.

Sincerely,

CPSE Chairperson

=====

I consent to the provision of special education services identified above. I understand that when a preschool setting has been identified where my child will receive the special education services in the setting recommended on the IEP these providers will change.

Signature of Parent

Date

CPSE LETTERHEAD

FINAL NOTICE OF RECOMMENDATION
NO SERVICE INITIAL RECOMMENDATION

Date: _____

Dear Parent/Guardian:

On _____, the Committee on Preschool Special Education (CPSE) conducted a meeting to discuss the educational needs of your child. You were invited to attend that meeting. As a result of the meeting, the CPSE found that your child does not have an educational disability and is not eligible for special education services. You have received a copy of your child's evaluation reports and a summary report of these evaluations.

Should you wish to discuss this final recommendation further, please call:

(Contact person) _____ at (_____) _____
or write to me at the CPSE address to arrange a meeting with the CPSE. You may bring other individuals who have knowledge or special expertise regarding your child. If you or your child have a disability which may require special arrangements, or if you need a translator or interpreter for the deaf, please notify the above person.

If, after a meeting with the CPSE, you still do not agree with the recommendation, you have the right to request Mediation or an Impartial Hearing. Your request for Mediation should be directed, in writing, to the CPSE Chairperson. You may request an Impartial Hearing by writing to the NYC Department of Education, 131 Livingston Street, Room 201, Brooklyn, N.Y., 11201.

The law provides you with certain rights including procedural safeguards, in connection with this recommendation. Your New York State Education Department Procedural Safeguards Notice is attached.

If you have any questions about this recommendation, I would be glad to discuss them with you. Please call me at the following number (_____) _____, or write to the CPSE at the address above to arrange a meeting.

Sincerely,

Committee on Preschool Special Education

Attachments:
New York State Education Department Procedural Safeguards Notice

Child's Name: _____ **CSE Case #:** _____

NYC ID#: _____ **DOB:** _____

Home Address: _____

Mail to:



THE NEW YORK CITY DEPARTMENT OF EDUCATION

JOEL I. KLEIN, Chancellor

SCHOOL PROGRAMS & SUPPORT SERVICES
52 Chambers Street, Room 220 · New York, NY 10007

FINAL NOTICE OF RECOMENDATION

Return to:

Date Letter Sent: _____

Dear Parent/Guardian:

On ____/____/____ the Committee on Preschool Special Education (CPSE) conducted a meeting to discuss the educational needs of your child. You were invited to attend that meeting. As a result of that meeting, the following recommendations were made.

Classification: _____

"X" ONE BOX ONLY

Program: _____

10 Month or 12 Month

Related Service(s): _____

Service Category: _____

Site/School: _____ NYC Preschool Code #: _____

Address: _____

If you agree with the CPSE recommendation and wish to have these services provided to your child, please sign the bottom of the form and return it to the Committee on Preschool Special Education immediately. Keep a copy for your records.

Attached you will find the current Individualized Education Program (IEP) describing test or reports upon which the recommendation is based and other programs considered.

Should you wish to discuss this final recommendation further, please call _____ at (____) _____ or write to us at the CPSE address to arrange a meeting. You may bring other individual(s) who have knowledge or special expertise regarding your child. If you have a disability which may require special arrangements, or if you need a translator or interpreter for the deaf, please notify the above person.

If, after your meeting with CPSE you still do not agree with the recommendation, you have the right to request Mediation or an Impartial Hearing. You request for mediation should be directed, in writing to the CPSE Chairperson. You may request an Impartial Hearing by writing to the Department of Education, 131 Livingston Street, Room 201, Brooklyn, NY 11201.

The law provides you with certain rights, including procedural safeguards, in connection with this recommendation. The New York State Education Department Procedural Safeguards Notice is attached.

Sincerely,

Committee on Preschool Special Education, Chairperson

Attachments: Individualized Education Program
New York State Education Department Procedural Safeguards Notice

PLEASE SIGN AND RETURN THIS LETTER TO THE CPSE AT THE ADDRESS INDICATED ABOVE.

I have read this form and **CONSENT** to the provision of 10 month preschool services as recommended.

⇒ SIGNATURE OF PARENT/GUARDIAN _____ DATE: _____

I have read this form and **CONSENT** to the provision of July and August 12 month programming for my child.

⇒ SIGNATURE OF PARENT/GUARDIAN _____ DATE: _____

Attachments: Individualized Education Program
New York State Education Department Procedural Safeguards Notice

Child's Name: _____ CSE Case #: _____

NYC ID#: _____ DOB: _____

Home Address: _____



THE NEW YORK CITY DEPARTMENT OF EDUCATION

JOEL I. KLEIN, *Chancellor*

SCHOOL PROGRAMS & SUPPORT SERVICES
52 Chambers Street, Room 220 · New York, NY 10007

DOE APPROVAL AND AUTHORIZATION TO RECEIVE PRESCHOOL SPECIAL EDUCATION PROGRAM/SERVICE(S)

Child's Name: _____
Last

CPSE District: _____

Home Address: _____

NYC Student ID:

--	--	--

 -

--	--	--

 -

--	--	--

First

Date of Birth:

--	--	--

 -

--	--

 -

--	--	--

Month Day Year

Date Letter Sent:

--	--

 -

--	--

 -

--	--

Month Day Year

Dear Parent/Guardian:

I am pleased to inform you that the New York City Department of Education has approved your child's Individualized Education Program (IEP).

Your child is eligible to receive **Special Class/Special Class in an Integrated Setting Services** as specified on his/her IEP beginning on ____/____/____:

Preschool: _____

Program: _____

Ten Months

Two Months (July-August)

Address: _____

Telephone #: _____

Your child is eligible to receive the **Special Education Itinerant Service** specified on his/her IEP beginning on ____/____/____/____ provided by _____.

These services will be provided to your child at _____

sessions per Week: _____

Ten Months

Two Months (July-August)

Your child is eligible to receive the following **Related Service(s)** specified on his/her IEP beginning on:

Date: ____/____/____ ____/____/____ ____/____/____ ____/____/____

Service: _____

Freq/duration: _____

Initial location: _____

Ten Months Two Months Ten Months Two Months Ten Months Two Months Ten Months Two Months

Transportation service has been recommended as part of your child's special education program as follows:

School bus

Other _____

Specialized transportation service(s)

Specify: _____

Ten Months

Two Months (July-August)

You will be notified shortly as to the first day of transportation service.

If you have any questions about the recommended service or transportation, please telephone the Committee on Preschool Special Education.

Sincerely,

Name

Title

Attachments:

New York State Education Department Procedural Safeguards Notice

c: CPSE # _____, Chairperson: _____ (w/o attachment)

Department of Transportation: _____ (w/o attachment)

Preschool Service Provider: _____ (w/o attachment)

FOR OFFICE USE ONLY

Dates below reflect students first date of attendance or first date of legal absence

Program Recommendation Related Service(s)

FIRST	ATTEND	DATE	FIRST	ATTEND	DATE	NAME OF SERVICE PROVIDER												
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PROVIDERS MUST ENTER FIRST ATTEND DATE, RETAIN ONE COPY FOR FILE AND IMMEDIATELY SEND ONE COPY TO CPSE LISTED ABOVE.

PROVIDER LETTERHEAD

PRESCHOOL SPECIAL EDUCATION ITINERANT TEACHER (SEIT) ACCEPTANCE LETTER

DATE: _____

Dear BOE Preschool Administrator:

Based upon our review of the above referenced student's Individualized Education Program (IEP) dated ____/____/____ this letter confirms our ability to provide the level of SEIT services mandated on the IEP as of ____/____/____.

SEIT services will be provided by: _____.
Name of the Teacher

NYC School SEIT Code #: _____.

Half hour sessions per week: _____.

The language of instruction for this student: _____.

The SEIT provider will coordinate the provision of any related services (specify) _____, _____, identified on the student's IEP.

If there are any questions regarding this letter, please telephone _____ at (____) _____.

Sincerely,

SEIT Representative

c: Related Service Providers (if applicable)

NOTE: To accept a NYC student the provider must have a contract with the NYC Department of Education.

Child's Name: _____ CSE Case #: _____

NYC ID#: _____ DOB: _____

Home Address: _____

PRESCHOOL LETTERHEAD

PRESCHOOL ACCEPTANCE LETTER

DATE: _____

Dear CPSE Chairperson:

Based upon our review of the above referenced student's Individualized Education Program (IEP) dated, ____/____/____ this letter confirms our ability to provide the level of services mandated on the IEP as of ____/____/____.

This child will be placed in class # _____, which has a maximum class size/staffing ratio of _____ and conforms with the requirements of the IEP.

The current age range in this class is from _____ to _____ and the children all have similar management needs, exhibit similar physical and social developmental levels as well as functional levels of performance.

Related service(s) as indicated on the IEP will be provided as follows:

<u>Services Recommended</u>	<u>Sessions Per Week</u>	<u>Minutes Per Session</u>	<u>Maximum Group Size</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Language of instruction: _____ Check here if Alternate Interim Placement

Specialized equipment and adaptive devices, as mandated on the IEP, will be provided as follows:

If the school is unable to provide all services on the IEP and the CPSE still believes that this provider should be recommended as the service provider, **the specific services that will not be provided must be listed below.** The anticipated date of services, if known, should also be indicated.

If there are any questions regarding this letter, please telephone _____ at (____) _____.

Sincerely,

Preschool Provider Representative

c: Parent/Legal Guardian

NOTE: To accept a NYC student the provider must have a contract with the NYC Department of Education.

Child's Name: _____ CSE Case #: _____
District #: _____ NYC ID#: _____ DOB: _____
Home Address: _____

FINAL NOTICE OF RECOMMENDATION/MODIFICATION OF IEP

Date Letter Sent: ____ / ____ / ____ .

Dear Parent/Guardian:

On ____ / ____ / ____, the Committee on Preschool Special Education (CPSE) conducted a meeting to discuss the educational needs of your child. You were invited to attend that meeting. As a result of that meeting, the following recommendation was made by the CPSE:

Classification:	_____	July/August Program
Service Category:	_____	"X" <u>ONE</u> Box ONLY
Related Service(s):	_____	NO CHANGE - OR -
	_____	CHANGE TO:
Preschool:	_____	10 MONTH <u>OR</u> 12 MONTH
Address:	_____	Coordinator: _____
	_____	(Indicate Name When Applicable)

If you agree with this final recommendation, sign the bottom of this form and return this page to the CPSE as soon as possible. Keep the copy for your records.

Attached is a copy of the modified IEP and a notice describing your due process rights.

Should you wish to discuss this final recommendation further, please telephone the CPSE to arrange a meeting. You may bring other individuals who have knowledge or special expertise regarding your child. If you have a disability which may require special arrangements, or if you need a translator or interpreter for the deaf, please notify the above named person.

If after a meeting with the CPSE you still do not agree with the recommendation, you have the right to request Mediation or an Impartial Hearing. Your request for Mediation should be directed, in writing, to the CPSE Chairperson. You may request an Impartial Hearing by writing to the Department of Education, Room 201, 131 Livingston Street, Brooklyn, NY 11201. For a full description of your right to appeal, please refer to the attached copy of your due process rights.

The law provides you with certain rights, including procedural safeguards, in connection with this recommendation. The New York State Education Department Procedural Safeguards Notice is attached.

If we do not hear from you before ____ / ____ / ____, the recommended changes may be made. However, if you request a CPSE Review, Mediation, or an Impartial Hearing before this date, your child will continue to receive the program and service he/she is now receiving until all appeal procedures have been completed. In any case, you have the right to a CPSE Review, Mediation, or Impartial Hearing after that date even if your child's program is changed.

Sincerely,

Committee on Preschool Special Education

SECTION I

I have read this form and understand the recommendation indicated above.

⇒ SIGNATURE OF PARENT/GUARDIAN _____ DATE: _____

If your child is recommended for 12-month school year service(s) (July/August) **for the first time** and you agree with this recommendation, **YOU MUST SIGN CONSENT**. If you do not sign consent, July/August programming will **not** be provided.

SECTION II

I have read this form and consent to the provision of 12 month (July/August) programming.

⇒ SIGNATURE OF PARENT/GUARDIAN _____ DATE: _____

Attachments: Individualized Education Program (IEP)
New York State Education Department Procedural Safeguards Notice

c: Preschool Service Provider: _____ (without attachments)

Child's Name: _____ CSE Case #: _____

District #: _____ NYC ID#: _____ DOB: _____

Home Address: _____



THE NEW YORK CITY DEPARTMENT OF EDUCATION

JOEL I. KLEIN, *Chancellor*

SCHOOL PROGRAMS & SUPPORT SERVICES
52 Chambers Street, Room 220 · New York, NY 10007

**AUTHORIZATION OF THE IEP
-NO CHANGE-**

Child's Name: _____
Last First

CPSE District: _____ NYC Student ID: - -

Home Address: _____ Date of Birth: - -
Month Day Year

Date Letter Sent: - -
Month Day Year

Dear Parent/Guardian:

It has been determined that the recommendation of the Committee on Preschool Special Education (CPSE) is appropriate and your child does not require a change in the special education services s/he is currently receiving.

If you wish to further discuss this recommendation with a CPSE representative, please telephone _____ at () _____ or you may write to the CPSE to arrange a meeting.

The law provides you with certain rights, including procedural safeguards, in connection with this recommendation. Attached is a copy of the New York State Education Department Procedural Safeguards Notice.

Sincerely,

Committee on Preschool Special Education

Attachment:

New York State Education Department Procedural Safeguards Notice

c: Preschool Service Provider: _____ (without attachment)

or
CPSE Letterhead

MEMORANDUM

TO: _____ Date: _____
FROM: _____ Re: _____
Student's Last Name, First
SUBJECT: Change Notice/Determination of Status _____ DOB: _____
NYC Student Identification # _____

Section I (To be used to correct/change student's name, date of birth, NYC Identification #)
Current: _____ Change to: _____

Section II (To be used for change of address)
Date of Change: _____
Previous Address: _____ New Address: _____
Telephone # _____ Telephone # _____
District # _____ District # _____

Section III (To be used when the provider has been notified by the parent that the child is to be withdrawn from the program)
Date the student was withdrawn from program: _____
(Please affix any written correspondence received from parent)

Section IV (To be used when provider cannot ascertain reason for absence for five (5) consecutive school days or the student does not attend at any time within twenty (20) days of the authorized first attend date.)
Student Status: [] Enrollment never established
[] Enrollment established through attendance
[] Enrollment established by reason of legal excuse
Dates of student's absence From: _____ To: _____
Provider's efforts to ascertain reason for absence: _____

Signature of Service Provider: _____ Date: _____

Section V (To be used by CPSE staff to provide notification to the service provider regarding the student's status)
Student Status: [] The Provider may retain the student on register
[] The Provider must discharge the student from its register
as of _____ (date cannot predate this notice)

COMMENTS

Signature of the CPSE Representative: _____ Date: _____

**APPLICATION TO THE COMMISSIONER OF EDUCATION
FOR APPROVAL TO ATTEND A SCHOOL
FOR THE BLIND, DEAF OR SEVERELY PHYSICALLY HANDICAPPED
PRESCHOOL**

**NEW YORK STATE EDUCATION DEPARTMENT-OFFICE FOR SPECIAL EDUCATION SERVICES
55 HANSON PLACE, ROOM 516
BROOKLYN, NY 11217-1580
TELEPHONE: (718) 722-4544**

**PHC-10
INSTRUCTIONS**

1. Please **PRINT** or **TYPE** in completing application.
2. Attach the following medical reports as applicable.

FOR A DEAF CHILD – A current audiological examination report (done within the past year).

FOR A BLIND CHILD – A current ophthalmological examination report (done within the past year).

SEVERELY PHYSICALLY HANDICAPPED – A current comprehensive medical evaluation from a physician which describes in detail the student’s physical disability and the functional limitations that the disability imposes on the student’s ability to benefit from education in a regular school setting.

NOTE: During the processing of this Application it is necessary that your child remain in his or her current placement to ensure the continuity of his or her educational **program**.

For further assistance in completing this Application please contact the Regional Office listed above.

M: _____ F: _____

1. Child’s Name: _____ DOB: _____ / _____ / _____
(Last) (First) (Middle) Month Day Year

2. Address: _____
(Street) (City) (Zip Code)

3. County of Location: _____

4. Telephone Number: _____
(Area Code) (Number)

5. Local School District of Residence: _____

6. Parents’ Names: _____
(Father) (Mother)

or name of legal guardian where appropriate: _____

7. Indicate how long child has been a resident of New York State: _____



THE NEW YORK CITY DEPARTMENT OF EDUCATION

JOEL I. KLEIN, Chancellor

SCHOOL PROGRAMS & SUPPORT SERVICES
52 Chambers Street, Room 220 · New York, NY 10007

FINAL NOTICE OF RECOMMENDATION

Return to: [Empty box]

Date Letter Sent: _____

Dear Parent/Guardian:

On ____/____/____ the Committee on Preschool Special Education (CPSE) conducted a meeting to discuss the educational needs of your child. You were invited to attend that meeting. As a result of that meeting, the following recommendations were made pending approval by the State Education Department (SED).

Classification: _____

"X" ONE BOX ONLY

Program: _____

10 Month [] or 12 Month []

Related Service(s): _____

Service Category: _____

Site/School: _____ NYC Preschool Code #: _____

Address: _____

If you agree with the CPSE recommendation and wish to have these services provided to your child, please sign the bottom of the form and return it to the Committee on Preschool Special Education immediately. Keep a copy for your records.

Attached you will find the current Individualized Education Program (IEP) describing test or reports upon which the recommendation is based and other programs considered.

Should you wish to discuss this final recommendation further, please call _____ at (____) _____ or write to us at the CPSE address to arrange a meeting. You may bring other individual(s) who have knowledge or special expertise regarding your child. If you have a disability which may require special arrangements, or if you need a translator or interpreter for the deaf, please notify the above person.

If, after your meeting with CPSE you still do not agree with the recommendation, you have the right to request Mediation or an Impartial Hearing. You request for mediation should be directed, in writing to the CPSE Chairperson. You may request an Impartial Hearing by writing to the Department of Education, 131 Livingston Street, Room 201, Brooklyn, NY 11201.

The law provides you with certain rights, including procedural safeguards, in connection with this recommendation. The New York State Education Department Procedural Safeguards Notice is attached.

Sincerely,

Committee on Preschool Special Education, Chairperson

Attachments: Individualized Education Program
New York State Education Department Procedural Safeguards Notice

PLEASE SIGN AND RETURN THIS LETTER TO THE CPSE AT THE ADDRESS INDICATED ABOVE.

[] I have read this form and CONSENT to the provision of 10 month preschool services as recommended.

[Signature line] SIGNATURE OF PARENT/GUARDIAN DATE: _____

[] I have read this form and CONSENT to the provision of July and August 12 month programming for my child.

[Signature line] SIGNATURE OF PARENT/GUARDIAN DATE: _____

Attachments: Individualized Education Program
New York State Education Department Procedural Safeguards Notice

Child's Name: _____ CSE Case #: _____

NYC ID#: _____ DOB: _____

Home Address: _____

~CPSE – SOPM APPENDIX B~

APPENDIX B

**TRANSITION TIMELINES
FROM EARLY INTERVENTION**

TO

COMMITTEE ON PRESCHOOL SPECIAL EDUCATION

**INSTRUCTIONS FOR COMPLETION
PERMISSION TO INITIATE TRANSITION PLANNING**

Rev 2/0

The parent should complete and sign the **Permission to Initiate Transition Planning** at the IFSP meeting closest to the date of the child's eligibility for CPSE, according to the chart below. The service coordinator should keep a copy of the completed form in the child's chart and send a copy to the parent, all service providers(including respite providers), and the EI Regional Office.

CHILD'S BIRTH DATE	START TRANSITION PLANNING AT IFSP MEETING PRIOR TO:	WRITTEN NOTICE MUST BE SENT TO CPSE WHEN PARENT HAS CHOSEN THAT OPTION *	WRITTEN REFERRAL MUST BE SENT TO CPSE WHEN PARENT HAS CHOSEN THAT OPTION*	DATE BY WHICH CHILD IS FIRST ELIGIBLE TO RECEIVE SERVICES FROM CPSE	DATE CHILD MUST LEAVE EARLY INTERVENTION
September 1, 1997 - December 31, 1997	February 2000	March 1, 2000	April 1, 2000	July 1, 2000 (12 month approval) September 1, 2000 (10 month approval)	December 31, 2000
January 1, 1998 - June 30, 1998	August 2000	September 1, 2000 or March 2001*	October 1, 2000 or April 2001*	January 1, 2001	August 31, 2001
July 1, 1998 - August 31, 1998	February 2001	March 1, 2001 or September 1, 2001*	April 1, 2001 or October 1, 2001*	July 1, 2001 (12 month approval) September 1, 2001 (10 month approval)	August 31, 2001
September 1, 1998 - December 31, 1998	February 2001	March 1, 2001	April 1, 2001	July 1, 2001 (12 month approval) September 1, 2001 (10 month approval)	December 31, 2001
January 1, 1999 - June 30, 1999	August 2001	September 1, 2001 or March 1, 2002*	October 1, 2001 or April 1, 2002*	January 1, 2002	August 31, 2002
July 1, 1999 - August 31, 1999	February 2002	March 1, 2002 or September 1, 2003*	April 1, 2002, or October 1, 2003*	July 1, 2002 (12 month approval) September 1, 2002 (10 month approval)	August 31, 2002
September 1, 1999 - December 31, 1999	February 2002	March 1, 2002	April 1, 2002	July 1, 2002 (12 month approval) September 1, 2002 (10 month approval)	December 31, 2002
January 1, 2000 - June 30, 2000	August 2003	September 1, 2003 or March 2004*	October 1, 2003 or April 1, 2004*	January 1, 2003	August 31, 2003
July 1, 2000 - August 31, 2000	February 2003	March 1, 2003 or September 1, 2004*	April 1, 2003 or October 1, 2003*	July 1, 2003 (12 month approval) September 1, 2003 (10 month approval)	August 31, 2003

* Please refer to the Protocol for more specific information regarding these dates.

~CPSE – SOPM APPENDIX C~

APPENDIX C

NEW YORK CITY COMMITTEES

PRESCHOOL SPECIAL EDUCATION

DOE PRESCHOOL ADMINISTRATORS

1/25/07

REGION	NAME/ADDRESS	PHONE	FAX
(1) EDGARDO SANTIAGO Chairperson, Acting (718) 329-8074 1 Fordham Plaza Bronx, NY 10458	CPSE #9 Marlene Berger Jose Gonzalez Luz A. Quinones 1 Fordham Plaza Bronx, NY 10458	(718) 329-8000 (718) 329-8069 (718) 329-8066 (718) 329-8102	(718) 741-8070
	CPSE #10 Elsie Alvarado Maxine Mitchell Helen Berman Rosetta Brownlee 1 Fordham Plaza Bronx, NY 10458	(718) 329-8000 (718) 329-8092 (718) 329-8068 (718) 329-8104 (718) 329-8103	(718) 741-7927 (718) 741-7929

REGION	NAME/ADDRESS	PHONE	FAX
(2) MICHELE BEATTY Chairperson (718) 794-7428, 29 3450 E. Tremont Ave. Bronx, NY 10465 1230 Zerega Ave. Bronx, NY 10462	CPSE #8 2nd FLOOR Jody Wanchel-Leonard Renee Covington Sherri Gold 1230 Zerega Ave. Bronx, NY 10462	(718) 828-5250 (718) 828-5351 (718) 828-5344	(718) 828-6864
	CPSE #11 Carlene Sabb Maria Mendoza-Rivera William Carr	(718) 828-5094 (718) 828-5093 (718) 828-5021	(718) 828-6864
	CPSE #12 Theresa Sullivan Orlando Rodriguez 1230 Zerega Ave. Bronx, NY 10462	(718) 828-4757 (718) 828-3860	(718) 828-6865

REGION	NAME/ADDRESS	PHONE	FAX
(3) CLAUDIA BLOCK Chairperson (Acting) (718) 281-3460 30-48 Linden Place Flushing, NY 11354 Flushing, NY 11354	CPSE #25 Karen Spector Vicki Eskenazi 30-48 Linden Place Flushing, NY 11354	(718) 281-7554 (718) 281-3446	(718) 281-3478
	CPSE #26 Thomasina Vignogna 30-48 Linden Place	(718) 281-3478 (718) 281-7556	
	CPSE #28 Joan Mestecky Nanci Schindler 90-27 Sutphin Boulevard Jamaica, NY 11435	(718) 557-2500 (718) 557-2679 (718) 557-2671	(718) 557-2670
	CPSE #29 Lorraine M. Tucker Diane Guzman Vivan Zeif (CPSE 29 and 28) 90-27 Sutphin Boulevard Jamaica, NY 11435	(718) 557-2500 (718) 557-2828 (718) 557-2672 (718) 557-2765	(718) 557-2670

REGION	NAME/ADDRESS	PHONE	FAX
(4)	CPSE #24 - 3rd FLOOR Elena I. Viglianco Vacant Charlotte Hollander Richard G. Games 28-11 Queens Plaza North Long Island City, NY 11101	(718) 391-6729 (718) 391-6729 (718) 391-6176 (718) 391-6174	(718) 391-6511

DOE PRESCHOOL ADMINISTRATORS

REGION	NAME/ADDRESS	PHONE	FAX
(4)	ESTHER MORELL Chairperson (718) 391-8522 Fax (718) 391-8522 28-11 Queens Plaza N. 5 th Fl. Long Island City, NY 11101	CPSE #30 - 3rd FLOOR Gypsy Olmann-Waithe (718) 391-6302 Fatmeh Farokhi (718) 391-6251 Vacant (718) 391-8336 Jennifer Luna Lozano (718) 391-8338 28-11 Queens Plaza North Long Island City, NY 11101	(718) 391-6511
		CPSE #32 - 3rd FLOOR Rosa Toro (718) 391-6157 28-11 Queens Plaza North Long Island City, NY 11101	(718) 391-6511

REGION	NAME/ADDRESS	PHONE	FAX
(5)	IVY LINDER (IA) Chairperson (718) 642-5836 82-01 Rockaway Blvd. Ozone Park, NY 11416	CPSE #19 Evangeline Rouse (718) 642-5800 Phyllis James (718) 642-5720 82-01 Rockaway Blvd. Ozone Park, NY 11416	(718) 642-5788
		CPSE #23 James Meditz (718) 348-2919 82-01 Rockaway Blvd. Ozone Park, NY 11416	(718) 642-5788
		CPSE #27 Susan Saban (718) 642-5800 Jessica Rodriguez (718) 642-5719 Laverne Ferguson (718) 642-5714 Robin Dobroff (718) 642-5718 82-01 Rockaway Blvd. Ozone Park, NY 11416	(718) 642-5788

REGION	NAME/ADDRESS	PHONE	FAX
(6)	ARLENE ROSENSTOCK Chairperson (718) 758-7600 Satellite Office 1780 Ocean Avenue Brooklyn, NY 11210	CPSE #17 2nd FLOOR Cindy Kanterman (718) 968-6200 Angel Cuevas (718) 968-6275 Chantal Forger (718) 968-6273 Glenn Simms (718) 968-6274 5619 Flatlands Avenue Brooklyn, NY 11234	(718) 758-7640
		CPSE #18 2nd FLOOR Seth Kranz (718) 968-6200 5619 Flatlands Avenue Brooklyn, NY 11234	(718) 968-6134
		CPSE #22 2nd FLOOR Marlene Morris (718) 968-6200 Michelene Culliton (718) 968-6277 Margaret Moscariello (718) 968-6278 Lillie Epner (718) 968-6276 5619 Flatlands Avenue Brooklyn, NY 11234	(718) 758-7640

REGION	NAME/ADDRESS	PHONE	FAX
(7)	CLAIRE DONNELLAN Chairperson (718) 420-5755 715 Ocean Terrace, Bldg. A Staten Island, NY 10301	CPSE #20 Diana O'Brien (718) 759-4950 Phyllis Schweiger (718) 759-3935 Carol Eisner (718) 759-4825 Elise Finkel (718) 759-4865 415 89 th Street Brooklyn, NY 11209	(718) 759-4880
		CPSE #21 Faye Neil (718) 759-3900 Flor de Maria Rubinos (718) 759-4831 Barry Raskin (718) 759-4898 415 89 th Street Brooklyn, NY 11209	(718) 759-4880

DOE PRESCHOOL ADMINISTRATORS

REGION	NAME/ADDRESS	PHONE	FAX
(7)	CPSE #31 2nd FLOOR	(718) 420-5700	(718) 420-5787
	Ruth Jimenez	(718) 420-5794	
	Youree Garcia	(718) 420-5793	
	Albert Juliano	(718) 420-5791	
	Hanah Rezmovits	(718) 420-5795	
	Ron Gill	(718) 420-5796	
	715 Ocean Terrace, Bldg. A Staten Island, NY 10301		

REGION	NAME/ADDRESS	PHONE	FAX
(8)	CPSE #13		(718) 935-3226
	Veronica Ross	(718) 935-3973	
	Vacant	(718) 935-3967	
	131 Livingston Street, Room 411 Brooklyn, NY 11201		
	CPSE #14	(718) 935-3226	
	Paul Beharry	(718) 935-3947	
	Maureen Carney	(718) 935-3946	
	131 Livingston Street, Room 411 Brooklyn, NY 11201		
	CPSE #15	(718) 935-3226	
	Vacant	(718) 935-3949	
	Mary Ann Governale	(718) 935-3948	
	131 Livingston Street, Room 411 Brooklyn, NY 11201		
	CPSE #16	(718) 935-3226	
	Betty Miller	(718) 935-3975	
	131 Livingston Street, Room 411 Brooklyn, NY 11201		

REGION	NAME/ADDRESS	PHONE	FAX
(9)	CPSE #1		(917) 339-1466
	Lisa Saracuse	(917) 339-1642	
	333 7 th Avenue New York, NY 10001		
	CPSE #2 4th FLOOR		(917) 339-1466
	Frances Zawacky	(917) 339-1645	
	Peggy Winkelman	(917) 339-1641	
	Alice Sigel	(917) 339-1647	
	333 7 th Avenue New York, NY 10001		
	CPSE #4		(917) 339-1466
	Maria Carrion	(917) 339-1646	
	333 7 th Avenue New York, NY 10001		
	CPSE #7		(917) 339-1466
Irene De Soysa	(917) 339-1648		
333 7 th Avenue New York, NY 10001			

REGION	NAME/ADDRESS	PHONE	FAX
(10)	CPSE #3	(212) 342-8300	(212) 342-8407
	Jose Lopez	(212) 342-8337	
	Milta Zeno	(212) 342-8333	
	388 West 125 th Street New York, NY 10027		
	CPSE #5	(212) 342-8300	(212) 342-8407
	Sybil Ewing	(212) 342-8336	
	388 West 125 th Street New York, NY 10027		
	CPSE #6	(212) 342-8300	(212) 342-8407
	Jeannetta Walsh	(212) 342-8335	
	Mary Jo Fisher	(212) 342-8334	
	388 West 125 th Street New York, NY 10027		

MARILYN SPRECHER
Chairperson
 (212) 342-8300
 388 West 125th Street
 New York, NY 10027

~~CPSE – SOPM APPENDIX D~~

APPENDIX D

SED DEFINITIONS AND CODES

FOR

PLACEMENT LOCATIONS

CPSE SOPM APPENDIX D

Instructions and Definitions for Completing the PD-4 Report

1. Report information **only** for those students with disabilities for whom this school district, school, or agency has primary CPSE or CSE responsibility on December 2, 1996.
2. Report information for **all** students with disabilities (ages 3 to 21) who were the primary responsibility of this district's/school's/agency's CPSE or CSE and received special education programs or services on December 2, 1996. (School districts should not report information for students with disabilities placed in the State-Operated schools in Rome and Batavia. Information for such students will be reported by the State-Operated schools.) Article 81 schools should **only** report information for students who are placed by State agencies, not for students placed by the public school districts pursuant to Section 4402 of the Education Law.
3. Complete each page of the report.

Directions for Section A

For public school districts only, enter two numbers, reflecting those students with disabilities (preschool students ages 3 to 5, and school-age students ages 4 to 21) who were **placed by their parents or guardians in regular education parochial or other private schools** (at their parents' expense) but were provided special education programs or services through the public school district, at public expense. Preschool students are also reported in Section B and school-age students in Section C.

Directions for Section B

This section contains a single Table in which to report placement information for all students with disabilities, ages 3 to 5, who were the primary responsibility of your CPSE and received preschool special education programs or services pursuant to Section 4201 or 4410 of the Education Law, on December 2, 1996. This table also requests your projected enrollment for 1997-98 school years for each setting. Please review the following definitions before completing this section.

Definitions for Section B

Line 1 Early Childhood Setting

Unduplicated total who received all of their special education and related services in programs designated primarily for children without disabilities. This may include, but is not limited to:

- Private preschools,
- Head Start Center,
- Child care facilities,
- Regular preschool classrooms open to an eligible prekindergarten population by the public school system,
- Home/early childhood combinations,
- Home/Head Start combinations
- Special class in an integrated setting and
- Other combinations of early childhood settings.

Line 2 Early Childhood Special Education Setting

Unduplicated total who received all of their special education and related services in State Education Department approved programs designed primarily for children with disabilities housed in regular school buildings or other community based settings. This may include, but is not limited to:

- Special education classrooms in regular public school buildings,
- Special education programs/services in child care facilities or other community based settings,
- Special education classrooms in trailers or portables outside regular school buildings, and
- Special education programs/services in neutral sites (e.g., libraries) or in the therapist's office.

Line 3 Home

Unduplicated total who received special education itinerant teacher services and/or related service in the principle residence of the child's family or caregiver.

Line 4 Itinerant Services Outside the Home, in a Hospital

Unduplicated total who received all of their special education and related services at a hospital for a short period of time, up to 3 hours per week on an outpatient basis. (This category does not include children receiving services at home.) These services may be provided individually or to small group of children.

Please note that preschool students who received special education or related services at hospital for more than 3 hours per week on a outpatient basis, should be reported in Line 5 Part-Time Early Childhood/Part-Time Early Childhood Special Education Setting, if a portion of services are provided at home or in a regular education program; or in Line 2, Early Childhood Special Education setting, if all the special education is provided in the hospital setting.

Preschool students receiving special education or related services at a hospital on an inpatient basis, should be reported in Line 6. Residential Facility.

Line 5 Part-Time Early Childhood Setting/Part-Time Early Childhood Special Education Setting

Unduplicated total who received services in multiple settings, such that: 1) portion of the special education and related services are provided at home or in programs designed primarily for children without disabilities, and 2) the remainder of their special education and related services are provided in programs designed primarily for children with disabilities. This may include, but is not limited to:

- home/early childhood special education combinations,
- HeadStart, child care, nursery school facilities, or other community based settings, with special education provided outside of the regular class,
- regular prekindergarten classes with special education provided outside of the regular class,
- separate school/early childhood combinations, and
- residential facility/early childhood combinations.

Line 6 Residential Facility

Unduplicated total who received all of their special education and related services in publicly or private operated residential schools, or residential medical facilities on an in-patient basis.

Line 7 Separate School

Unduplicated total who received all of their special education and related services in educational programs in public or private day schools specifically for children with disabilities.

Column D Total Number of Students ages 3-5 Placed in Each Setting
Total of ages 3 to 5 for each placement setting.

Column E Projected Counts of Preschool Students in Each Setting

Based on projected student enrollment for 1997-98 school year and local initiatives to promote placement in the Least Restrictive Environment, report the projected counts of preschool student with disabilities, ages 3-5 for each setting.