**NWRESD Low Incidence Regional Services**

**Request for Regional Services and/or Eligibility Evaluation**

**Check only one box below:**

|  |
| --- |
| Request for Assistance With Eligibility Determination  Initial Eligibility  Out-of-State Move-in  Request to Initiate Regional Services  New Regional Eligibility  Student is an in-state move-in |

|  |  |  |
| --- | --- | --- |
| **Regional Disability Category:**  Autism Spectrum Disorder (ASD)  Deaf / Hard of Hearing (D/HH)  Vision Impairment (VI)  Orthopedic Impairment (OI) | **Referring Agency:**  Local School District  EI / ECSE | **Interpreter Required?**  Language:  District Provided  Consent to Bill for Interpreter Services |

**Student Information:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Student First Name | Last Name | Middle Initial | Gender  Male Female | Date of Birth |
| SSID# | Grade | Current Sped Eligibilities  Choose an item. | | Date of IEP/IFSP |
| Home Address | | City | State | Zip |
| Primary Contact | | Relationship | Primary Ph# | Alternate Ph# |
| Secondary Contact | | Relationship | Primary Ph# | Alternate Ph# |

**School / Program Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Case mgr. / School Contact Name | Position | Phone | Email |
| Resident School | Resident District | County | |
| Attending School | Attending District |  | |
| Special Education Director Signature (required):  x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date |

|  |  |  |  |
| --- | --- | --- | --- |
| **Submit to:** | LIRP Intake Specialist  NWRESD Low Incidence Regional Services  5825 NE Ray Circle  Hillsboro, Oregon 97124  PH: 503-614-1404: FAX: 503-614-1285 | **Date Sent to Regional Office:** |  |
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**Please see page 2 for required supporting documents.Please submit the following required documents:**

|  |  |  |
| --- | --- | --- |
|  | **Eligibility Determination:** | **Initiation of Regional Services:** |
| ASD | Completed **Regional Request Form**  Copy of signed **consent**  **Note:** If requesting assistance with eligibility, please discuss with your regional ASD consultant to determine which evaluation components will be completed by the home district / program and which will be completed by the ASD consultant. | Completed **Regional Request Form**  Copy of current **eligibility**  Copy of current **IEP / IFSP** |
| DHH | Completed **Regional Request Form**  Copy of signed **consent** including:   * File review * Classroom observation * Audiological evaluation (if one has not been recently completed) * Other assessments to be administered by district staff   **Note**: If requesting an audiological evaluation by NWRESD, submit a **Form 30** for payment. | Completed **Regional Request Form**  Copy of current **eligibility**  Copy of current **IEP / IFSP** |
| VI | Completed **Regional Request Form**  Copy of signed **consent** including:   * **Functional Vision Assessment** * Signed **Report of Eye Exam** from an ophthalmologist or optometrist on NWRESD form. | Completed **Regional Request Form**  Copy of current **eligibility**  Copy of current **IEP / IFSP**  Copy of **Functional Vision Assessment**  Copy most recent **Report of Eye Exam**.  Copy of **Learning Media Assessment** (if available |
| OI | Completed **Regional Request Form** | Completed **Regional Request Form**  Copy of current **eligibility**  Copy of current **IEP / IFSP**  Copy of **Medical Statement** |