



Livingston Educational Service Agency  
 Department of Special Education  
 1425 W. Grand River Avenue, Howell MI 48843  
 Phone: (517) 540-6822 Fax: (517) 546-7047

## HOMEBOUND EDUCATIONAL SERVICES REFERRAL

Revised 11/08/11

Referral Date: \_\_\_\_\_ School Building: \_\_\_\_\_  
 Student Name: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Gender:  M  F Grade: \_\_\_\_\_

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

Medical Reason for Absence: \_\_\_\_\_  Physician's Statement Attached (REQUIRED)  
 Start Date on Physician's Statement: \_\_\_\_\_ End Date on Physician's Statement: \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_

	<u>Subject</u>	<u>Teacher</u>
<b>Student Schedule</b>	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Name of Person Making Referral: \_\_\_\_\_ Title: \_\_\_\_\_  
 Projected Duration: \_\_\_\_\_ Amt. of time per week: \_\_\_\_\_  
 Superintendent/Designee Signature \_\_\_\_\_ Date: \_\_\_\_\_  
Required before services can begin  
 Building Principal Signature \_\_\_\_\_ Date: \_\_\_\_\_  
Required before services can begin  
 Special Ed. Director Approval Signature\* \_\_\_\_\_ Date: \_\_\_\_\_  
IEP required with referral-Special Ed Students\* Required before services can begin (\*only for students in special education)

When completed, send to: Secretary, Assistant Superintendent for Employee Services  
 Livingston Educational Service Agency  
 1425 West Grand River Avenue  
 Howell, MI 48843 Fax: 517-546-7047  
 Email: kimcalderon@livingstonesa.org

Date Received by LESA: \_\_\_\_\_  
 LESA Approval: \_\_\_\_\_ Title: Executive Director of Special Education  
 Date Assigned: \_\_\_\_\_ Assigned to: \_\_\_\_\_

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