VALLEY SCHOOL DISTRICT **SPECIAL EDUCATION**
555 West Valley Rd, Yakima, WA 98902 Phone: (509) 456-8596 Fax: (509) 658-9856

Transfer Verification of Eligibility and IEP Program

Student name **Jason Patterson** Student # **49** DOB **2/6/2002** Date **11/24/2008**
Home school _____ IEP Mgr **Steve Bigelow** Grade **1** Age **6 y 9 m**
Ethnicity _____ Language _____ Gender **M**
Parent Name(s) _____ Adult Student ☐
Parent Address **4690 Edsel Road** City **City Of Commerce** St **CA** Zip **90040**
Parent Work _____ Parent Home **818-404-0831** Needed: Surrogate Parent ☐ Parent Interpreter ☐
Disability _____ Previous District _____ Reeval Due Date **?**

Previous School Placement and Related Services:

☐ Resource Room ☐ Self-Contained: _____ ☐ Other: _____
☐ Speech/Language ☐ Occupation/Physical Therapy ☐ Other: _____

Eligibility Confirmation:

☐ Careful review of the most recent Evaluation Report in this child's Special Education records indicates that the evaluation procedures followed were consistent with the requirements of WAC 392-172A, and that they substantially document his/her eligibility to receive Special Education services in accordance with the terms of the disability category described above.

☐ Accept Eval ☐ Accept IEP
☐ Don't Accept Eval ☐ Don't Accept IEP

Additional Information:

Program/Placement:

The following program/placement is believed to be the Least Restrictive Environment consistent with this child's disability condition and recommended program needs.

School Placement: Alder Elementary **ESY:** ☐ No ☐ Yes

Related Services: ☐ SLP ☐ OT/PT ☐ Other _____

Goals Areas:
☐ Written Language ☐ Reading ☐ GM ☐ Math ☐ FM
☐ Organiz. Skills ☐ Social Skills ☐ Vocational ☐ Self-Help ☐ Cognitive
☐ Language ☐ Articulation ☐ Behavior

Valley School District will:

Amendments to minutes as below:

Regular Classroom Service	min/week: _____	SLP Services	min/week: _____
Special Ed Services	min/week: _____	Other Services_____	min/week: _____
OT/PT Services	min/week: _____	Nonacademic settings	min/week: _____

Other categorical Programs: _____

IEP Team: ☐ Counselor ☐ Parent ☐ Teacher ☐ OT/PT ☐ SLP ☐ IEP Teacher ☐ Nurse

Date of most recent IEP:_____ **IEP Due Date:**?_____ **Initiation of Services Date:** _____

NOTICE OF ACTION: Special Education Services will be initiated upon completion of the IEP meeting. Option of not providing services considered but rejected due to the fact that the student qualifies and is in need of services**.** Signature indicates acceptance of the current IEP and consent for receipt of special education services. ☐ Procedural Rights Offered.

_____ *Initials*

_____*Parent/Adult Student Signature* _____ *Date*

As parent/guardian of the named student (or as the named student, if an adult)

I ☐ **Do** ☐ **Do Not** give my consent for the district to submit the above name and birth date to the Department of Social and Health Services (DSHS) to verify Medicaid eligibility.

Distribution: o Student Services o Cum File o Parent o Psychologist o IEP Teacher