



COMMONWEALTH OF MASSACHUSETTS  
 EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
**Department of Children and Families**

DEVAL L. PATRICK  
*Governor*

★  
 JOHN W. POLANOWICZ  
*Secretary*

★  
 ERIN C. DEVENEY  
*Interim Commissioner*

[Insert date]

**Notice to LEA (Local Education Agency)**

This notice is being sent for the following reason(s) *(Check all that apply)*:

- A child in DCF care or custody:  has entered or changed placement  
 is entering or transferring to a new school *(Send Notice to both LEAs)*
- A TEAM Evaluation or Re-evaluation is requested for a child in DCF care or custody.  
***(PLEASE CONSIDER THIS NOTICE AS A REQUEST FOR A TEAM EVALUATION/RE-EVALUATION.)***
- To request educational information about a child *(Check information needed)*:  
 Child's records/transcripts     Most recent TEAM Evaluation & IEP     School contact
- To confirm foster care status of child for eligibility for free school meals.

**Part 1: Student Information** *(Provide information known to date)*

Student's Name:			Grade Level:	
Date of Birth:    /    /	Age:	Sex:	SASID:	
Address where child currently resides:			Phone:	
Current Residence Type: <input type="checkbox"/> Home <input type="checkbox"/> Foster/Adoptive Home <input type="checkbox"/> Intensive Foster Care (IFC) Home <input type="checkbox"/> Shelter/STARR/TCU <input type="checkbox"/> Hospital/CBAT <input type="checkbox"/> Group Home <input type="checkbox"/> Temp. Foster Care (McKinney-Vento) <input type="checkbox"/> Residential Treatment <input type="checkbox"/> Other <i>(Please specify)</i> :				
Name of Residence (if applicable):				
Parent's Name, Address & Phone (if different from above): <i>(If address cannot be verified, please complete "Request for School District Assignment" form:</i> <a href="http://www.doe.mass.edu/sped/28MR/28m2.doc">http://www.doe.mass.edu/sped/28MR/28m2.doc</a> . <i>)</i>				
Person to Contact in Emergency:				
Relationship:			Phone:	
DCF Social Worker:			Phone:	
DCF Supervisor:			Phone:	
DCF Area Office:			Phone:	
Student's Current School (or School Student is Transferring from):				
Address:			Phone:	
Contact Person:			Title:	
Date Withdrawn (if applicable):				

Doc. ID: CMNLAD

Revised: 9/2014



**Part 2: Student's New School (or School Student is Transferring to)**

Not applicable

School Name:	
LEA/School District Name:	
Address:	Phone:
Contact Person:	Title:
Date Enrolled:	

**Attention Former School:** *This form confirms withdrawal of the student named above. Please ensure that all school records, including IEPs and discipline records, have been or, as of the receipt of this notice, are promptly forwarded to the student's new school district and send a copy of all records to the DCF Social Worker. Thank you.*

**Part 3: Student's Special Education Status**

Does the child have a **current IEP** (Individualized Education Program)?

**Yes** (Please complete the following information regarding the current placement)

Current Placement Type:	Date of Last Team Meeting:
<input type="checkbox"/> Current services appropriate <input type="checkbox"/> Current services <b>not</b> appropriate; please consider this notice as a request for a Re-evaluation	
Student's Educational Decision-Maker (Check only one)	
<input type="checkbox"/> Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Special Education Surrogate: <input type="checkbox"/> Assigned <input type="checkbox"/> Requested <input type="checkbox"/> Other (Please specify):	

**No**, child is not receiving special education services.

**No**, but child is suspected of having a disability.

This request for a TEAM Evaluation is being made for the following reasons:		
Suspected Disability: (Check all that apply)		
<input type="checkbox"/> Autism	<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Intellectual Impairment
<input type="checkbox"/> Sensory Impairment	<input type="checkbox"/> Neurological Impairment	<input type="checkbox"/> Emotional Impairment
<input type="checkbox"/> Communication Impairment	<input type="checkbox"/> Physical Impairment	<input type="checkbox"/> Specific Learning Disability
<input type="checkbox"/> Health Impairment (Including ADD or ADHD)		

**Should you have any questions concerning this student or the information or requests made on this form, please contact the DCF Social Worker at the number listed above. Thank you.**

**Social Worker Signature/Date** \_\_\_\_\_

**Attachments** (Check all applicable items)

- For a child in DCF CUSTODY, copy of the mittimus or other court order
- For a child in a DCF OPEN CASE or in DCF CARE, authorization to release information signed by parent/guardian
- To support a TEAM Evaluation or Re-evaluation request, any recent testing or evaluations completed concerning the child's suspected disability and eligibility for special education services