COMMONWEALTH OF MASSACHUSETTS / BUREAU OF TRANSITIONAL PLANNING

CHAPTER 688 STUDENT REFERRAL FORM

Directions: 1) Complete **only one** referral form per student. 2) Clearly print or type information. 3) Mail the **original** referral form with a current IEP and the most recent assessments to the selected human service agency (see list below). 4) Next, mail **only** a copy of referral form to the Bureau of Transitional Planning (BTP). **If you cannot determine the human service agency**, then and only then mail original form with required documentation to the BTP. 5) Keep one copy in the student record.

STUDENT INFORMATION: **DATE COMPLETED:** _____

Student Name:_____ DOB: _____/_____/_____ Sex: ☐ M ☐ F

Last First

Language Spoken: _____ S.S.#: _____/_____/_____ Receives SSI/SSDI: ☐ Yes ☐ No ☐ Unknown

Present Address: _____ Phone: _____

Parent/Guardian Name: _____ Legal Guardian: ☐ Yes ☐ No

(circle one) Last First

Address (if different from student): _____

Phone (if different from student):_____ Language Spoken (if different from student):_____

SCHOOL DISTRICT/PROGRAM INFORMATION:

School District (LEA):_____ Final Date of SPED Service: _____/_____/_____

LEA Address: _____

LEA Contact Person: _____ Phone: _____

Name Role

Specific Program Location: _____

Type of Placement: _____ List All Funding Agencies:_____

Please check each area below in which the student demonstrates serious functional limitations.

☐ Behavioral/Social/Emotional ☐ Communication ☐ Medical/Physical ☐ Cognition ☐ Blind ☐ Visually Impaired ☐ Deaf
☐ Hard of Hearing ☐ Traumatic Head Injury ☐ Other (specify)_____

CHAPTER 688 REFERRAL SENT TO: (Choose only one.)

☐ Department of Social Services (DSS) ☐ Department of Mental Retardation (DMR)
☐ MA Rehabilitation Commission (MRC) ☐ Department of Mental Health (DMH)
☐ Department of Youth Services (DYS) ☐ MA Commission for the Blind (MCB)
☐ MA Commission for the Deaf and Hard of Hearing (MCDHH)

Specify, *if applicable*, Area Office sent to:

☐ Bureau of Transitional Planning ***(Send original form and records here only if an appropriate agency could not be determined.)***

I hereby authorize the release of all personal information contained in this student's records, including medical and educational evaluations, to the Bureau of Transitional Planning at EOHHS and to any member agencies for the purpose of eligibility determination and transitional planning. I also authorize the release of any other personal information concerning this student that is required during the transitional planning process by any state agency to any other state agency.

_____
_____
Date Signature of Student 18 or over -or- Legal Guardian (Circle one.)

_____ _____ _____
Date Signature of Special Education Director/Designee Phone Number

Bureau of Transitional Planning, Executive Office of Health and Human Services, Room 1109
1 Ashburton Place, Boston, MA 02108
Phone: 617-727-7600 Fax: 617-727-1396