



Livingston Educational Service Agency
 Serving Howell Public Schools
 Department of Special Education
 411 North Highlander Way, Howell MI 48843
 Phone: (517)548-6358 Fax: (517) 548-6242



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>
Student Schedule	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

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 Human Resources
 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: _____

