

# COMMONWEALTH OF MASSACHUSETTS CHAPTER 688 REFERRAL FORM

## Directions

- 1) Mail the original referral form with a copy of the current IEP, the TPF (Transition Planning Form, 28M/9), and the most recent assessments to one human service agency (see list below).
- 2) If you don't know which agency to select or more than one agency seems appropriate send items in #1 (above) to the BTP.

**STUDENT INFORMATION** SASID#: \_\_\_\_\_ Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

Name: \_\_\_\_\_ (first) \_\_\_\_\_ (last) Language Spoken: \_\_\_\_\_

SSN: \_\_\_\_\_ Receives SSI/SSDI?  Yes  No  Unknown

Disability Category: Primary \_\_\_\_\_ Secondary \_\_\_\_\_ Level of Need:  high  moderate  low

Parent/Guardian Name \_\_\_\_\_ Legal Guardian?  Yes  No Language Spoken: \_\_\_\_\_ (optional)

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**SCHOOL DISTRICT/PROGRAM INFORMATION** Is this student expected to graduate before age 22?  Yes, expected date: \_\_\_\_/\_\_\_\_/\_\_\_\_  No, expected date of SpEd termination: \_\_\_\_/\_\_\_\_/\_\_\_\_

School District (LEA): \_\_\_\_\_ LEA Address: \_\_\_\_\_

LEA Contact Person: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Name of High School: \_\_\_\_\_

Type of Placement: \_\_\_\_\_ List All Funding Agencies: \_\_\_\_\_

School/Educational Placement: \_\_\_\_\_ Address: \_\_\_\_\_

*Signature of Special Education Director/Designee* \_\_\_\_\_ Date: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**REFERRAL SUBMISSION:** Send to **ONLY ONE** of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> Department of Children & Families (DCF) | <input type="checkbox"/> Department of Developmental Services (DDS)           |
| <input type="checkbox"/> Department of Mental Health (DMH)       | <input type="checkbox"/> MA Commission for the Deaf & Hard of Hearing (MCDHH) |
| <input type="checkbox"/> MA Rehabilitation Commission (MRC)      | <input type="checkbox"/> MA Commission for the Blind (MCB)                    |

If you don't know which agency, or more than one agency seems appropriate, please send to:  
 The Bureau of Transitional Planning at One Ashburton Place, Room 1109, Boston, MA 02108

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 transition 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.

Signature of Student (18 or over) or Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_