SPOTSYLVANIA COUNTY SCHOOLS
REQUEST FOR ASSISTANCE

School_____Date Submitted to Principal or CST: (circle which one) _____

Child's Name _____ Date of Birth_____ Age _____

Child's Address _____

Parent/Guardian/Surrogate _____

Present Grade Present Teacher(s)

REASON FOR REQUEST FOR ASSISTANCE
List the academic/developmental, behavioral, and social/emotional problems and/or concerns you have about the student.

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Describe any attempts that have been made to resolve these problems and/or concerns (include interventions and teacher/parent involvement).

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Certain special education evaluation and service may be reimbursable through Medicaid.

□ Check if the student is eligible for Medicaid and fill in the following information:

_____Medicaid Eligibility Number (if available)

Parental consent will be obtained to release educational records to the Department of Medical Assistance.

_____ _____
Signature of Person Making Referral Relationship to Student

_____
Date parent contacted by referring source