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| Logo  Description automatically generated**PAGE 1 – FOR PROGRAM ENROLLMENT 2024-2025****\*\*Acceptance upon Final Review of Records by BOCES\*\*****SEND ALL PAPERWORK TO BOCES STUDENT DATA CENTER:** SDC@BTBOCES.ORG – FAX: 607-763-3614 – INTEROFFICE: ED CENTER #20 |
| *S T U D E N T D E M O G R A P H I C S*  |
| *First Name (Legal Name):* | *MI:* | *Last Name:* | *Affirmed Name (if different from legal):* |
|       |   |       |       |
| *Birth Date:* | *Gender:* | *Grade: (As of Sept ‘24)* | *Hispanic:* | *Race:* | *Home Language:* |
|       | FMNon-binary |      | [ ]  **Yes**  or [ ]  **No** | \_\_\_\_\_ |       |
| *School District:* | *Dist School Bldg:* | *District of Residence:* | *Local Student ID #:* | *9th Grade Entry (Sept):* |
|       |       |       |       |       |
| *Disability:*  | If the student is classified, please attach the IEP.If the student has a BIP, please include it. | *ELL Years:* |
|   |  |       |
|  |
| *Meal Status:* | *Assessment Type:*  |
| [ ]  **Free** [ ]  **Not Free** [ ]  **Reduced** | [ ]  **NYS Assessments** [ ]  **NYS Alternate Assessments** |
|  |
| *Student’s Mailing Address & Phone:* |
|       |
| *Parent/Guardian Information 1:*  | *Relationship:*        | *Lives with this Guardian:*  [ ] Yes **or**  [ ]  No |
| ***Name:***  |       |
| ***Address:*** |       |
| ***Home Phone:*** |       | ***Cell Phone:*** |       | ***Email Address:*** |       |
| *Parent/Guardian Information 2:*  | *Relationship:*       | *Lives with this Guardian:* [ ] Yes  **or**  [ ] No |
| **Name:**  |       |
| **Address:**  |       |
| ***Home Phone:***  |       | ***Cell Phone:*** |       | ***Email Address:*** |       |
|[ ]  *ADD/CONTINUE STUDENT:* If this placement is an Additional Request for Services, please process an ARFS form PRIOR to enrollment. |
| BOCES Site: | BOCES Program: | Session: |
|  |  | [ ]  ***AM***  [ ]  ***PM***[ ]  ***All Day*** |
| CTE Course: | Session: |
|       | [ ]  *AM*  [ ]  *PM*  [ ]  *All Day* |
| Tentative Start Date: | Note: Program/Course enrollment is on a “First Come-First Served” basis, except CTE. |
|       |  |
|[ ]  ***CHANGE STUDENT PLACEMENT:*** |  |
| ***FROM BOCES Site:*** | ***FROM BOCES Program or Course:*** | ***Session:*** |  |
|  |  | [ ]  ***AM***  [ ]  ***PM*** [ ]  ***All Day*** |  |
| ***TO BOCES Site:*** | ***FROM BOCES Program or Course:*** | ***Session:*** |  |
|  |  | [ ]  ***AM***  [ ]  ***PM*** [ ]  ***All Day*** |  |
| ***Desired Effective Date:*** |  |  |
|[ ]  ***DROP STUDENT:* If student is enrolled in multiple BOCES programs, please specify ALL program(s)/service(s) to discontinue.** **PLEASE NOTE: Drops are processed on the date received in the BOCES Student Data Center and CANNOT be back dated.** |  |
| ***FROM BOCES Site:*** | ***FROM BOCES Program or Course:*** |  |
|  |  |  |
| ***Desired Effective Date:*** |  | ***Drop Reason:*** |  |  |
| **Signature** *(ADMIN/CSE/CNSLR)*: |  | Date: |  |  |

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| Logo  Description automatically generated**PAGE 2 - FOR RELATED SERVICES REQUESTS 2024-2025****SEND ALL PAPERWORK TO BOCES STUDENT DATA CENTER:** SDC@BTBOCES.ORG – FAX: 607-763-3614 – INTEROFFICE: ED CENTER #20 |
| *RELATED SERVICES* |
| ***First Name (Legal Name):*** | ***MI:*** | ***Last Name:*** |
|       |   |       |
| ***This Student is in a BOCES program:*** | [ ]  Yes **or** [ ] No | ***This is a Request For Related Services ONLY:*** | [ ] Yes **or** [ ]  No |
| [ ]   | ***PROVIDE/ADD RELATED SERVICES AS REQUESTED BELOW:* (New Services)** |
| [ ]   | ***DISCONTINUE EXISTING SERVICES AS REQUESTED BELOW:*  (Please only specify the services to discontinue)** |
| *Effective Date:* | *Location of Service:* |
|  |  |
|  | **Services** | **FREQ** | **MIN** | **CYCLE** | **G/I** | **AND/OR** | **FREQ** | **MIN** | **CYCLE** | **G/I** |
|[ ]  **SKILLED NURSE** |    |  | \_\_\_\_ | \_\_ |  |  |  | \_\_\_\_ | \_\_ |  |
|[ ]  **STUDENT PHYSICAL *(Grades K,1,3,5,7,9 & 11 – also, any new student to BOCES)*** |  |
| **Check all that apply and select % - ONLY possible choices are 50%, 100%** |  |
|[ ]  **Aide**  |[ ]  **Monitor**  |[ ]  **Interpreter**  |[ ]  **Scribe *(% TBD by BOCES*)**  |  |
| Below are the ONLY Related Services offered by BOCES – they are NOT INCLUDED in program & generate additional costs.  For clarification, contact Tammy Eaves at 763-3318. |  |
|[ ]  **Counseling *(In addition to Program)*** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Indirect Consultant Teacher** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Direct Consultant Teacher** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Subject Area:** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Subject Area:** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Subject Area:** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Subject Area:** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Family Training/Counseling** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Occupational Therapy** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Physical Therapy - Please Include Prescription** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Adaptive PE*****(In Addition to Program)*** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Speech (Disabled)** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Hearing Impaired** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Visually Impaired** |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]   |    |  | \_\_\_\_ | \_\_ |  |    |  | \_\_\_\_ | \_\_ |  |
|[ ]  **Amended IEP Attached** *(Indicate changes made***):** |  |  |
|[ ]  **Individual Evaluation:** | ***Reason:*** |  |  |
|  |  | ***Referred by:*** |  |  |
| **Signature** *(ADMIN/CSE)*: |  | Date: |  |