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| **PAGE 1 – FOR PROGRAM ENROLLMENT 2025-2026**  **\*\*Acceptance upon Final Review of Records by BOCES\*\***  **SEND ALL PAPERWORK TO BOCES STUDENT DATA CENTER:**  [SDC@BTBOCES.ORG](mailto: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 ‘25)* | | | | *Hispanic:* | | *Race:* | | | | | | *Home Language:* | |
|  | | | | F M Non-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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| **PAGE 2 - FOR RELATED SERVICES REQUESTS 2025-2026**  **SEND ALL PAPERWORK TO BOCES STUDENT DATA CENTER:**  [SDC@BTBOCES.ORG](mailto: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)*** | | | | | | | | |  | |  | | \_\_\_\_ | \_\_ | |  | | |  |  | | \_\_\_\_ | \_\_ |  | |
|  | **Direct Consultant Teacher** | | | | | | | | |  | |  | | \_\_\_\_ | \_\_ | |  | | |  |  | | \_\_\_\_ | \_\_ |  | |
|  | **Subject Area:** | | | | | | | | |  | |  | | \_\_\_\_ | \_\_ | |  | | |  |  | | \_\_\_\_ | \_\_ |  | |
|  | **Subject Area:** | | | | | | | | |  | |  | | \_\_\_\_ | \_\_ | |  | | |  |  | | \_\_\_\_ | \_\_ |  | |
|  | **Subject Area:** | | | | | | | | |  | |  | | \_\_\_\_ | \_\_ | |  | | |  |  | | \_\_\_\_ | \_\_ |  | |
|  | **Subject Area:** | | | | | | | | |  | |  | | \_\_\_\_ | \_\_ | |  | | |  |  | | \_\_\_\_ | \_\_ |  | |
|  | **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: |  | | | | | |