Livingston EDUCATIONAL SERVICE Agency

HOME-BASED EDUCATIONAL SERVICES REFERRAL

Referral Date: _____ School Building: _____

Student Name: _____ Grade: _____

Birth Date: _____ Gender: ☐ Male ☐ Female

Special Ed. Eligibility: ☐ Does Not Apply ☐ ASD ☐ CI ☐ D-B ☐ ECSE ☐ EI ☐ D/HH ☐ OHI ☐ PI ☐ SCI ☐ SLD ☐ SLI ☐ SXI ☐ TBI ☐ VI

Parent/Guardian: _____ Phone Number: _____

Address: _____

Student Schedule

Subject	Teacher & Teacher Email

Name of Person Making Referral: _____ Title: _____

Projected Duration: _____ to _____ ☐ Ongoing for FAPE Purposes

(student is over 10-day cumulative suspension day threshold)

Amount of Time per Week: _____

Central Office: _____ Date: _____

Required before services can begin (includes approval of additional time for exams/testing/teacher consultation)

Special Education Director: _____ Date: _____

Required before services can begin

When Completed, Sent to: Assistant Superintendent for Special Education c/o Omega Rainer

Livingston Educational Service Agency

1425 W. Grand River Ave.

Howell, MI 48843 Email: OmegaRainer@LivingstonESA.org

Date Received by Livingston ESA: _____

Livingston ESA Approval: _____ Title: Asst. Superintendent for Special Education

Date Assigned: _____ Assigned To: _____

Rev. 10/2026