Livingston EDUCATIONAL SERVICE Agency

# HOMEBOUND 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

Medical Reason for Absence: _____ ☐ Physician's Statement Attached*

* REQUIRED

Start Date on Physician's Statement: _____ End Date on Physician's Statement: _____

Parent/Guardian: _____ Phone Number: _____

Address: _____

Student Schedule

| Subject | Teacher & Teacher Email |
|---|---|
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| | |
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| | |
| | |
| | |

Name of Person Making Referral: _____ Title: _____

Projected Duration: _____ to _____ Amount of Time per Week: _____

Superintendent/Designee Signature: _____ Date: _____

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

Building Principal: _____ Date: _____

Required before services can begin

Special Education Director: _____ Date: _____

Required before services can begin (* only for student in Special Education)

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