

DDS Name and address

Attach label or type in claimant name and SSN

REQUEST FOR ADMINISTRATIVE INFORMATION

**This form should be completed by the person(s) most familiar with the child's records.
Continue any answers as needed on next page.**

Name of School: _____

1. Has there been any recent evaluation or testing of this child? <u>If yes, kind(s) of test/evaluation:</u> <u>Date(s):</u>			
Please send us copies of any tests or evaluations, including progress reports, triennial assessments, psychological or speech evaluations, current Individualized Education Programs, and any other records that can help us evaluate the child's functioning.			
2. Has the child been referred for assessment team evaluation or special class placement or services? <u>If yes, to whom?:</u> <u>Date(s):</u>			
3. Current Instructional Levels:			
	<u>Standardized Assessment Instrument:</u>	<u>Score/Percentile Rank:</u>	<u>Date(s):</u>
Reading level: _____	_____	_____	_____
Math level: _____	_____	_____	_____
Written Lang. level: _____	_____	_____	_____
4. Grade(s) repeated, if any: (circle)			
K 1 2 3 4 5 6 7 8 9 10 11 12			
5. Educational Disabilities, if any:			
<input type="checkbox"/> Mental Retardation/Mentally Impaired/ Intellectually Limited		<input type="checkbox"/> Other Health Impairment (please specify)	
<input type="checkbox"/> Hearing Impairment/Deafness		<input type="checkbox"/> Specific Learning Disability (please specify)	
<input type="checkbox"/> Speech or Language Impairment		<input type="checkbox"/> Developmental Delay (please specify)	
<input type="checkbox"/> Visual Impairment/Blindness		<input type="checkbox"/> Multiple Disabilities (please specify)	
<input type="checkbox"/> Emotional Disturbance/Behavior Disorder			
<input type="checkbox"/> Orthopedic Impairment			
<input type="checkbox"/> Autism			
<input type="checkbox"/> Traumatic Brain Injury			
6. Placement and Related Services (Check all that apply):			
<input type="checkbox"/> Regular Education , no special instruction <input type="checkbox"/> Special Ed. Instruction:		Therapies, etc.:	
_____ Hours/week:		_____ Hours/week:	
<input type="checkbox"/> Inclusion – Sp instr. in regular class	_____	<input type="checkbox"/> Occupational Therapy	_____
<input type="checkbox"/> Resource Room	_____	<input type="checkbox"/> Physical Therapy	_____
<input type="checkbox"/> Self-contained, regular school	_____	<input type="checkbox"/> Speech-Language Therapy	_____
<input type="checkbox"/> Self-contained, special school	_____	<input type="checkbox"/> Counselling (please specify)	_____
<input type="checkbox"/> Special school, non-public	_____	<input type="checkbox"/> Other (please specify)	_____
<input type="checkbox"/> Residential	_____		

Please sign on next page.

ADDITIONAL COMMENTS Use this section for continuation of any answers from page 1, and for any additional information about this child's records that may help us obtain the information we need to evaluate the child's functioning.

Signature/Title

Date

Phone

Signature/Title

Date

Phone

THANK YOU

The Privacy and Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 1614 and 1633 of the Social Security Act. Social Security needs this information to make a decision on the named claimant's claim. This form is authorized under CFR 416.924a(a). While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security Offices. If you want to learn more about this, contact any Social Security office.

This information collection meets the clearance requirements of 44 U.S.C., section § 3507, as amended by section 2 of the **Paperwork Reduction Act of 1995**. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you 15 minutes, on average, to complete this form. This includes the time it will take to read the instructions, check the appropriate blocks, and provide narrative when needed.