CUYAHOGA COUNTY
Board of Developmental Disabilities

High School Transition Referral Form

DATE__________________

DOB: _____________ SS#___________________ SEX: M___ F___

LAST NAME_______________________ FIRST NAME__________________ M. I.___ A.K.A.__________

ADDRESS____

CITY_________________________ STATE: ______________________ ZIP: ________

HOME PHONE_(____) ___________________ WORK :_(___) __________________

Medicaid#:_____________________________ Custody of Department of Children and Family Services Y N

REFERRED BY: (CIRCLE ONE) AGENCY/SELF/GUARDIAN/PARENT/FAMILY MEMBER/SIGNIFICANT OTHER

NAME: ___________________________________ AGENCY: ___________________________________

ADDRESS____

CITY: _________________________ STATE: _________________________ ZIP: _______________

E-MAIL:_________________________________ Phone Number: _____________________

PARENT/FAMILY/SIGNIFICANT OTHERS/FOSTER PARENTS:		**LEGAL GUARDIAN :(IF APPLICABLE)**	
NAME:___________________________________		NAME:_______________________________________	
ADDRESS:________________________________		ADDRESS:____________________________________	
____		____	
HOME PHONE_______________	WORK PHONE______________	HOME PHONE________________	WORK PHONE________________

NATURE OF DISABILITY:____

____

____

Primary Language Spoken: ___________________

-Over-

REASON FOR REFERRAL

______ Eligibility Only   ______ Transition Services

Anticipated date of Graduation: ___________________

Eligibility Only: The individual go through the intake and eligibility process. They will then be closed to CCBDD. When there is another services needed in the future, they will be opened up to the appropriate service.

Transition Services: Graduation is no more than 2 years away and it is the appropriate time for vocational planning to begin. (A Support Administrator will be assigned in the last year of school)

Does the individual know that they are being referred for CCBDD Services? YES NO

The following Information must accompany the referral for Eligibility:

______ Current Multi-Factored Evaluation or Education Training Report
______ Current Individual Education Plan
______ Current Medical (if available)
______ Documentation of the Disability (if it is not contained in the information above)
______ Release of Information
______ Copy of Birth Certificate
______ Copy of Social Security Card

The following Information must accompany the referral for Transition Services:

______ Current MFE
______ Current IEP
______ Release of Information

Send to:
Cuyahoga County Board of Developmental Disabilities
Intake Department
1275 Lakeside Avenue East
Cleveland, OH 44114
E-Mail: intake@cuyahogabdd.org

Fax: (216) 861-0253
Phone: (216) 736-2673

10/1/10tjl Update 1/13/11