



The State I-Team

OUR VISION

Every child in Vermont who has significant learning differences (severe/multiple disabilities) is welcome in her/his class and community, is taught well, has access to the I-Team as a valuable resource to families, schools, communities, and receives responses to needs in a timely way.

OUR MISSION

To assist local teams of families, educators, and other service providers in the delivery of quality educational services to students with intensive educational needs through technical assistance, professional development, support for systems change and family support.

The **State I-Team** is funded by the Vermont State Department of Education and is located on the campus of the University of Vermont in Burlington, VT. Regional offices are located in South Burlington, Montpelier, Middlebury, Brattleboro, and Newport, VT.

For more information contact:

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Mailing Address:

CDCI / UVM

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VERMONT I-TEAM STUDENT REFERRAL

School Year: _____

Date Referral Completed: _____

STUDENT INFORMATION

Name: _____

Date of Birth: _____

Parent(s)/ Guardian: _____

Address: _____

Telephone: _____

E-mail: _____

Additional Parent Info: _____

STUDENT PLACEMENT

School District : _____

School: _____ Grade: ____

Address: _____

Phone: _____

Schedule:
Full Day - Start and end times? _____

Other Schedule - Days and times? _____

Is a regular Team Meeting scheduled for this student?

Yes (when) _____ No

IEP TEAM SERVING STUDENT

Name/Team Role

*Indicate primary contact person with **

Contact Information

phone, email, alternate address

Service Coordinator/Case Manager

Special Education Teacher

Regular Education Teacher

Instructional Assistant

School OT

Home/Clinic OT

School PT

Home/Clinic PT

School SLP

Home/Clinic SLP

Other Team Roles / Names

Special Education Administrator _____

Principal: _____

Vision Consultant: _____

Hearing Consultant: _____

Nurse: _____

Other: _____

ELIGIBILITY

Check only one primary eligibility for Special Education reported to the Department of Education in Child Count:

- | | | |
|--|---|--|
| <input type="checkbox"/> Multihandicapped | <input type="checkbox"/> Deaf-Blind | <input type="checkbox"/> Learning Impaired |
| <input type="checkbox"/> Hard Of Hearing | <input type="checkbox"/> Deaf | <input type="checkbox"/> Speech or Language Impaired |
| <input type="checkbox"/> Visually Impaired | <input type="checkbox"/> Emotional Behavioral Disability | <input type="checkbox"/> Orthopedically Impaired |
| <input type="checkbox"/> Other Health Impairment | <input type="checkbox"/> Specific Learning Disability | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Developmentally Delayed (FITP or EEE only) | |

Is the student identified on the Deaf-Blind census? YES <input type="checkbox"/> NO <input type="checkbox"/> I DON'T KNOW <input type="checkbox"/>
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REFERRAL REQUESTS

REQUEST FOR TECHNICAL ASSISTANCE TO DEVELOP / MODIFY THE STUDENT'S PROGRAM

Note: Requests in this area are for providing technical assistance to your team for developing or modifying the student's instructional program, accommodations and supports or services. This section **should be completed by your team.**

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Teaming | <input type="checkbox"/> Family Support | <input type="checkbox"/> IEP Development | <input type="checkbox"/> Peer Relations |
| <input type="checkbox"/> Inclusion | <input type="checkbox"/> Specialized Instruction | <input type="checkbox"/> Communication | <input type="checkbox"/> Functional Skills |
| <input type="checkbox"/> Literacy | <input type="checkbox"/> Accommodations/Supports | <input type="checkbox"/> Related Services | <input type="checkbox"/> Assistive Technology |
| <input type="checkbox"/> Transition Planning | <input type="checkbox"/> Positive Behavioral Supports | <input type="checkbox"/> Vision/Hearing/Sensory Issues | |
| <input type="checkbox"/> Information on Disabilities | <input type="checkbox"/> Data-based Decisions | <input type="checkbox"/> Assessment Strategies | |
| <input type="checkbox"/> Other: _____ | | | |

REQUEST FOR TRAINING

Note: Requests in this area are for providing training to your team (including family members), to other school staff, students and/or community service providers. This section **should be completed by your team.**

Areas of Training (Check All that Apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Collaborative Teaming | <input type="checkbox"/> Family Support / Resources | <input type="checkbox"/> Peer Relationships |
| <input type="checkbox"/> IEP Development | <input type="checkbox"/> Specialized Instruction | <input type="checkbox"/> Communication |
| <input type="checkbox"/> Curriculum (e.g., academic, self-care, vocational, recreation) | <input type="checkbox"/> Assistive Technology | <input type="checkbox"/> Inclusion |
| <input type="checkbox"/> Positive Behavior Supports | <input type="checkbox"/> Vision/hearing/sensory issues | <input type="checkbox"/> Integration of Related Services |
| <input type="checkbox"/> Transitions | Other: _____ | |

Intended Audience (Check all that apply):

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Student's Team Members | <input type="checkbox"/> Paraeducators | <input type="checkbox"/> General Educators | <input type="checkbox"/> Administrators | <input type="checkbox"/> Family Members |
| <input type="checkbox"/> Related Service Providers | <input type="checkbox"/> Community Service Providers | <input type="checkbox"/> The Student's Peers | | |
| Other: _____ | | | | |

REQUEST FOR FAMILY SUPPORT

Note: The I-Team Family Resource Consultant will contact the family of the referred student to discuss the I-Team referral and will try to support the family to meet their needs. The selection **should be completed by the family.**

- | | |
|--|--|
| <input type="checkbox"/> Questions About my Child's Disability | <input type="checkbox"/> Connection with Another Family |
| <input type="checkbox"/> Information on Accessing Services | <input type="checkbox"/> Information on Accessing Resources |
| <input type="checkbox"/> Peer Relationships / Play Groups | <input type="checkbox"/> Summer Camps |
| <input type="checkbox"/> Home School Partnerships | <input type="checkbox"/> Supporting Skills at Home or in the Community |
| <input type="checkbox"/> Positive Behavior Supports | <input type="checkbox"/> Information on Support Groups |
| <input type="checkbox"/> Other: _____ | |

REFERRAL TYPE:

We understand that there will be no fee for initial referrals each year. Initial referrals are those referrals that require up to two on-site visits by I-Team Educational Consultant and/or the Family Resource Consultant. If we determine that we want additional days of on-site consultation, technical assistance and/or training for our Team beyond the two visits of the initial referral period or consultation from a Statewide Consultant (e.g., AAC/Communication, OT, PT), the school will be charged a once per year fee of \$395. Training for the school team is included in the \$395 referral fee. Training for other school personnel will be billed at \$90.00 per hour of actual training time (planning and travel time will not be billed).

We are requesting an Initial Referral _____

We are Requesting a Long-term Referral (a \$395 fee will be charged) _____

We are requesting training of other school staff. Amount to be billed with be determined after the training is planned and approved. _____

The bill should be sent to:

Name: _____ Position _____

Address: _____

REQUIRED ADMINISTRATOR PERMISSION

As the Special Education Director, I agree to support this team to request I-Team services, which may include school visits, record reviews, training to team members and parent contacts.

Special Education Director Signature: _____ Date: _____

REQUIRED FAMILY PERMISSION

I give permission for _____'s educational team to consult with members of the Vermont State I-Team regarding his/her educational program for the _____ school year. I-Team members have permission to access my child's educational files and to share information on my child with other I-Team members as needed to provide this assistance. I understand that there is no cost to me for these services and that strict confidentiality will be observed in the use of all information. I have given input regarding my priorities for I-Team assistance and understand that the school will keep me informed of all I-Team visits on behalf of my child.

Parent or Guardian Signature: _____ Date: _____

PARENT PERMISSION TO VIDEOTAPE

I give permission for Vermont State I-Team personnel or school personnel to videotape my child, _____, while engaged in educational activities in school, at home or in the community to share with I-Team members that are working with my child's educational team. Video clips may also be shared with our school team members as an information / training tool. All video clips will be shared with us if we desire to view them. The video clips are NOT to be used for any other purposes (e.g., during regional or statewide training of teachers or family members) unless we give specific written permission for that intended use.

Parent or Guardian Signature(s): _____ Date: _____

I-TEAM USE ONLY

REC: GI JL KS MSR TL CB TF Date Received: __/__/__