

ECHO JOINT AGREEMENT PROGRAM/SERVICE REFERRAL

Please complete this form when requesting a placement or service and return to:
ECHO Joint Agreement, 350 W. 154th St., South Holland IL 60473 (708) 333-7880

Date of Request	District:	Phone:	Fax:	
Referral Person:	Position:	Phone:	Fax:	
Address:				
Contact Person:	Position:	Phone:	Fax:	
Name (Last, First):		<p style="text-align: center;">EDUCATIONAL PROGRAMS</p> <input type="checkbox"/> Family Enrichment Program (0-3 yrs.) <input type="checkbox"/> Early Childhood Program (3-8 yrs.) <input type="checkbox"/> ECHO School (8-21 yrs.) <input type="checkbox"/> ECHO Satellite (6 yrs. to 8 th grade) <input type="checkbox"/> ECHO ABLE (6-21 yrs.) <input type="checkbox"/> Physically Health Impaired Program (5-21 yrs.) <input type="checkbox"/> Physically Health Impaired Itinerant (3-21 yrs.) <input type="checkbox"/> Visually Impaired Program (5-21 yrs.) <input type="checkbox"/> Visually Impaired Itinerant (3-21 yrs.) <input type="checkbox"/> Deaf & Hard of Hearing Program (3 yrs.-12 th grade) <input type="checkbox"/> Deaf & Hard of Hearing Itinerant (3-21 yrs.) <input type="checkbox"/> Communication Development (5 yrs.-8 th grade) <input type="checkbox"/> PACE SED Primary (3 rd -6 th grade) <input type="checkbox"/> PACE SED Junior High School (7 th -8 th grade) <input type="checkbox"/> PACE Reg. Ed. Alternate (6 th -8 th grade) <input type="checkbox"/> Academy For Learning SED (9 th -12 th grade) <input type="checkbox"/> Academy For Learning Reg. Ed. Alternate (9 th -12 th grade) <input type="checkbox"/> Community Based High School (9 th -12 th grade) <input type="checkbox"/> Inter-Cooperative Programs _____		
Address:				
City:	Zip:			
Birthdate:	Prim. Lang.			Sex <input type="checkbox"/> M <input type="checkbox"/> F
Student's School:	Grade:			
SIS #				
Medicaid #:				
Parent/Legal Guardian:				
Foster Parent:				
Home Phone:	Work Phone:			
Surrogate Parent:				
Home Phone:	Work Phone:			
DCFS Caseworker:	Phone:			
Address/City:				
Parent/Legal Guardian Signature (Optional)	Date			
Referring Person's Signature	Date			
Dist. Supt./Designee Signature	Date			
Joint Agreement Director Signature	Date			
Reason For Referral:				

EDUCATIONAL SERVICES

- Transition (JTPA)
- Inservice Training (Please describe below)
- IST: Student Collaboration (Please describe below)
- IST: Staff Development (Please describe below)
- Other (Please identify): _____

DIAGNOSTIC SERVICES

- Functional Vision Assessment Assistive Technology Assessment
 - Audiological Assessment (Sertoma)
 - Central Auditory Processing Disorder (CAPD) Evaluation
 - Early Childhood Assessment (0-8 yrs.): _____
 - Other: _____
- (Please Specify)

**PLEASE ATTACH CURRENT EVALUATION DATA AND ANY
PERTINENT MEDICAL OR SCHOOL RECORDS**

- Included are the following:
- Academic Motor Communicative Social/Emotional
 - General Intelligence Hearing/Vision Health
 - Other (Please Identify): _____

Date Received: _____

Sent To: _____ Date: _____

C.C. _____

(Name)

(District)