



SOUTHERN WESTCHESTER BOCES

BOARD OF COOPERATIVE EDUCATIONAL SERVICES

CENTER FOR SPECIAL SERVICES

1606 Old Orchard Street, White Plains, New York 10604

(914) 948-7271 • fax (914) 948-7598

Dear PPS Directors,

Thank you for your interest in enrolling a student with SWBOCES. We are excited to guide you through our intake process to ensure a smooth transition for the student.

To initiate the enrollment process, please complete the SWBOCES intake form attached to this email. Additionally, **submit** all necessary supporting documents, including:

- **Individualized Education Program (IEP)**
- **Most recent evaluations**
- **Report Card**
- **FBA/BIP if applicable**
- **Physical examination and relevant medical information**
- **Other relevant supporting documents**

You can also access the intake form directly at <https://specialservices.swboces.org/> under district forms - Student Intake Data Form. When scanning documents, please ensure that any landscape-oriented documents are scanned in the same orientation and not in portrait.

Once the form and supporting documents are ready, please email them to centralintake@swboces.org.

Our CSS Central Intake Committee meets every Tuesday at 8:30 am to review student submissions. Following the review, districts will be notified on Wednesday and Thursday regarding the program to which the student is being referred.

Please note that our clinical staff endeavor to follow up on scheduling intakes as soon as possible. In the event, they are unsuccessful in contacting a family (family unresponsive or contact information is not current), they will inform the district contact. Intake Referrals will remain open for an eight-week period with clinicians attempting contact. Please note that after eight weeks, the referral will be closed and will need to be resubmitted for consideration.

If you have any questions or concerns throughout the process, please don't hesitate to reach out to Rysheen Hagans, Intake Coordinator (rhagans@swboces.org) for assistance.

Thank you for choosing SWBOCES for the students' educational needs. We look forward to assisting you with the intake process.

Best regards,



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Referral Date:

Student's Information

Please provide the student's demographic information as listed on the IEP to ensure accurate processing of the referral.

Student's Full Name:

(Same as IEP)

Date of Birth (MM/DD/YYYY)

Age:

Current Placement:

Incoming Grade

Home Address:

City:

State, Zip

Gender:

Ethnicity:

Race:

**Student's Preferred
Pronouns**

Parent/Guardian's Information

Please provide the parent/guardian's contact information to ensure we can communicate regarding the student's referral.

Parent/Guardian's Full Name:

Home Phone:

Mobile Phone:

Parent/Guardian Email:

District Contact Information

Please provide the name, title, phone number, and email address of your district's designated contact person for student intake and referrals.

District:

Contact (First & Last Name):

Contact's Title:

Email:

Phone:

District Recommendation - Please indicate the district's recommendation for intake, including contact notification, school year length, and diploma/assessment type.

Notify District Contact before intake?
District contact above - Choose one below.

Recommended Year
Choose one below.

IEP Indicates:
Choose one below.

Yes

☐

No

☐

10 Mos.

☐

12 Mos

☐

**Standardized
Assessment**

☐

**NYSAA
Assessment**

☐



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Classification: *What is the student's current classification as indicated on their IEP?*

Please select the student's classification from their most recent IEP. This information is required by the Center for Special Services to ensure appropriate program placement and support.

Current Performance Levels			
Psych Test Name:		Educ. Test Name:	
IQ Testing Dates:		Educ. Test Date:	
Verbal Score:		Grade Level - Decoding:	
Performance Score:		Grade Level - Comprehension:	
Full Scale IQ:		Grade Level - Mathematics:	

Student Behavioral Profile (check all that apply)					
☐	Non-Compliant	☐	Depression	☐	Substance Abuse
☐	Self-Injury	☐	Anxiety	☐	Truancy
☐	Verbal Abuse	☐	Suicidal Ideation/Attempts	☐	Physical/Sexual Abuse
☐	Physical Aggression	☐	Somatic Symptoms	☐	Psychiatric Hospitalization

Signature of Person who
completed form.

Date completed