

SPECIAL EDUCATION DEPARTMENT

FORM 34-37 INSTRUCTIONS: This form is to be completed when a school district determines at an Individualized Education Program (IEP) meeting that the least restrictive environment for a student is a private residential placement. It must be submitted in a timely manner to allow approval prior to the district effecting the placement. Please note: No room and board reimbursement is available for students who are 22 years old or older. Complete and submit one copy of this application form PRIOR to placement, renewal due date, or change of placement. Applications may be submitted in sections. However, reimbursement will not be approved until all required documentation has been received. Application should be submitted to 3437RnB@isbe.net.

Check one:

☐ Initial Placement – Anticipated Start Date: _____ ☐ Continuing Placement ☐ Change of District or Facility Code

SECTION I: IDENTIFICATION (Items must match the information listed in I-Star.)

NAME OF STUDENT (LAST NAME / FIRST NAME - <i>Do not use nicknames.</i>)		STUDENT INFORMATION SYSTEM NUMBER
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	BIRTH DATE (MM/DD/YY)	REGION-COUNTY- DISTRICT-TYPE CODE
RESIDENT DISTRICT NAME AND NUMBER AND ADDRESS (Street, City, ZIP Code)		
NAME AND TITLE OF CONTACT PERSON FOR DISTRICT/CO-OP	TELEPHONE NUMBER (Include Area Code)	EMAIL
RESIDENTIAL or COMBINATION PRIVATE FACILITY CODE (Where student is located)	RESIDENTIAL PRIVATE FACILITY NAME AND ADDRESS (Street, City, ZIP Code)	
<i>Complete the section below if the Residential Private Facility code is a Residential Only code.</i>		
TUITION PRIVATE FACILITY CODE	TUITION PRIVATE FACILITY NAME AND ADDRESS (Street, City, ZIP Code)	

Use the codes from the key below to indicate the disability(ies) of the student.

Primary Disability _____ Secondary Disability, if identified _____ Tertiary Disability, if identified _____

DISABILITY KEY

A = Intellectual Disability	F = Hearing Impairment	K = Emotional Disability	O = Autism
C = Orthopedic Impairment	G = Deafness	L = Other Health Impairment	P = Traumatic Brain Injury
D = Specific Learning Disability	H = Deaf-Blindness	M = Multiple Disabilities	
E = Visual Impairment	I = Speech and/or Language Impairment	N = Developmental Delay	

For Initial Out-of-State Applications: Has an Illinois Department of Children and Family Services (DCFS) Interstate Compact been initiated if the student is under the age of 18? For information about an Interstate Compact, please contact DCFS at DCFS.InterstateCompactGeneral@illinois.gov.

☐ Yes ☐ No

Initial or Continuing Out-of-State Placement for all students: Complete the following.

☐ Yes ☐ N/A Prior to the placement of a child in an out-of-state special education residential facility: Did the school district inform the child and/or the parent/guardian of the option to place the child in a special education residential facility located within this state, if any, that provides treatment and services comparable to those provided by the out-of-state special education residential facility?

SECTION II: PLACEMENT INFORMATION

HISTORY OF SERVICES PROVIDED. Use the chart below to indicate the educational setting(s) in which the student has been placed for the last two school years. Indicate the primary disability code (see Disability Key in Section I) and the educational environment (EE) code. Enter the beginning and discontinued dates for each EE. Leave the disability code blank if the student was not identified as eligible for special education and was placed in regular education. *If a two-year history is not available, please enter the date and month/year when the student entered the district.*

DATE STUDENT ENTERED DISTRICT

Beginning Date		End Date		DISABILITY CODE (See key on page 1.)	EE CODE (See key below.)
Month	Year	Month	Year		

EDUCATIONAL ENVIRONMENT CODES AND BRIEF DESCRIPTION KEY

For additional details, see EE codes in [Students with Disabilities Data Collection and Approval Instructions for Use with I-Star manual](#).

- 01 = Special ed 80% or more of day inside regular classroom
- 02 = Special ed 40-79% of day inside regular classroom
- 03 = Special ed less than 40% of day inside regular classroom
- 04 = Full-time special ed class in a separate public day school that does not house programs for students without disabilities
- 05 = Full-time special ed class in a separate public day school that does not house programs for students without disabilities in conjunction with a student's placement in a residential facility
- 06 = Philip J. Rock Center and School
- 07 = Detention center or jail
- 08 = Private day or out-of-state public day program
- 09 = Private residential in-state
- 10 = Private residential out-of-state
- 11 = Homebound instructional program
- 12 = Hospital instructional program
- 13 = Illinois School for the Deaf
- 14 = Illinois School for the Visually Impaired
- 15 = Illinois Center for Rehabilitation and Education
- 16 = Illinois Department of Human Services
- 17 = Full-time program designed for children without disabilities with all special ed delivered in that setting (ages 3-5)
- 18 = Full-time special ed in program designed for children with disabilities housed in community-based settings (ages 3-5)
- 19 = Part-time special ed provided at home or in programs designed for children without disabilities and part-time special ed provided in programs designed for children with disabilities (ages 3-5)

SECTION III: SERVICES INFORMATION

SERVICES PROVIDED IN MOST RECENT PLACEMENT: This includes hospital instructional program, if applicable. Use the keys below to indicate the services and amount of time provided each week **in the most recent placement** described in Section II.

RELATED AND OTHER SERVICES CODES (See key.)	AMOUNT OF TIME PER WEEK (See key.)

REQUESTED SERVICES. Use the keys below to indicate the services and amount of time these are to be provided each week by the requested residential placement. This information should be in the student's current IEP.

RELATED AND OTHER SERVICES CODES (See key.)	AMOUNT OF TIME PER WEEK (See key.)

RELATED AND OTHER SERVICES KEY

- 01 = Adapted Physical Education
- 02 = Aide - Class
- 03 = Aide - Individual Student (Note if 16 or 24 hours)
- 04 = Art Therapy
- 05 = Audiology
- 06 = Brailist/Reader
- 07 = Counseling Services (Note if individual or group.)
- 08 = Consultant Services
- 09 = Adapted Driver Education
- 10 = Interpreter Services
- 11 = Assistive Device
- 12 = Music Therapy
- 13 = Occupational Therapy
- 14 = Outdoor Education
- 15 = Orientation and Mobility
- 16 = Other Related Services (Describe service in space provided.)
- 17 = Parent Counseling
- 18 = Psychological Services
- 19 = Physical Therapy
- 20 = Psychiatric Services
- 21 = Recreation
- 22 = School Health Services
- 23 = Speech/Language Services
- 24 = Social Work Services
- 25 = Transportation (Special)
- 26 = Career and Technical Education
- 27 = Transition/STEP by Division of Rehabilitation Services
- 28 = Behavioral Intervention Plan
- 29 = Competitive Employment
- 30 = Travel Training
- 31 = Acquisition of Daily Living Skills
- 32 = Supported Employment
- 33 = Supports for Transition to Postsecondary Education
- 34 = Interagency Linkages

AMOUNT OF TIME KEY

- 0 = Less than 1 hour
- 1 = 1 hour or more but less than 2 hours
- 2 = 2 hours or more but less than 3 hours
- 3 = 3 hours or more but less than 4 hours
- 4 = 4 hours or more but less than 5 hours
- 5 = 5 hours or more but less than 6 hours
- 6 = 6 hours or more but less than 7 hours
- 7 = 7 hours or more but less than 8 hours
- 8 = 8 hours or more but less than 9 hours
- 9 = 9 hours or more

SECTION IV: IEP AND EVALUATION DATES

DATE (MM/DD/YY)

* REQUIRED

* Date of the most recent Eligibility/Evaluation/Reevaluation Conference.

* Date of the *most recent* Individualized Education Program meeting that recommended this residential placement be made or continued.

* If different from above, date of the most recent IEP annual review.

Dates of supplemental evaluations, if applicable. Specify type:

Supplemental Evaluation: _____

Supplemental Evaluation: _____

SECTION V: AGENCY CONTACT

The district must show appropriate contacts with state or local agencies. These contacts can include those initiated by the district and/or student's family. Attach additional pages, as necessary. Use the codes provided in the key below to indicate the department(s) and agency(ies) that were contacted. Check the appropriate box(es) below to indicate services/assistance provided. Explain the results of all contacts and any resulting financial assistance. Copies of all correspondence regarding agency contacts, district requests, and agency responses should be maintained at the district level and **subject to review upon request**. If more space is needed, please attach additional page(s).

☐ Check this box if NO outside agencies have been contacted for this student.

DEPARTMENT/AGENCY KEY

A = Department of Public Aid
B = Department of Human Services
C = Department of Children and Family Services
D = Department of Corrections
E = County Probation Agency
F = Department of Public Health
G = Division of Specialized Care for Children
H = Community and Residential Services Authority

I = Local Mental Health Center
J = Local Youth Services Provider
K = Local Recreation Services Provider
L = Local Substance Abuse Services Provider
M = Private Counseling Service
N = Local Substance Abuse Services Provider
O = Private Counseling Service
P = State Psychiatric Hospital/Zone Center
Q = Other State/Local Agency

<p>____ DEPARTMENT/AGENCY CONTACTED (Use key above.)</p> <p><input type="checkbox"/> Participated in IEP Meeting <input type="checkbox"/> Assessment <input type="checkbox"/> Technical Assistance <input type="checkbox"/> Financial Assistance <input type="checkbox"/> Medical <input type="checkbox"/> Other (Explain at right.)</p>	<p>RESULTS OF CONTACTS/COMMENTS:</p>
<p>____ DEPARTMENT/AGENCY CONTACTED (Use key above.)</p> <p><input type="checkbox"/> Participated in IEP Meeting <input type="checkbox"/> Assessment <input type="checkbox"/> Technical Assistance <input type="checkbox"/> Financial Assistance <input type="checkbox"/> Medical <input type="checkbox"/> Other (Explain at right.)</p>	<p>RESULTS OF CONTACTS/COMMENTS:</p>
<p>____ DEPARTMENT/AGENCY CONTACTED (Use key above.)</p> <p><input type="checkbox"/> Participated in IEP Meeting <input type="checkbox"/> Assessment <input type="checkbox"/> Technical Assistance <input type="checkbox"/> Financial Assistance <input type="checkbox"/> Medical <input type="checkbox"/> Other (Explain at right.)</p>	<p>RESULTS OF CONTACTS/COMMENTS:</p>
<p>____ DEPARTMENT/AGENCY CONTACTED (Use key above.)</p> <p><input type="checkbox"/> Participated in IEP Meeting <input type="checkbox"/> Assessment <input type="checkbox"/> Technical Assistance <input type="checkbox"/> Financial Assistance <input type="checkbox"/> Medical <input type="checkbox"/> Other (Explain at right.)</p>	<p>RESULTS OF CONTACTS/COMMENTS:</p>

SECTION VI: NEED FOR PRIVATE RESIDENTIAL PLACEMENT — REQUIRED NARRATIVE

For Initial Applications

Please provide a narrative that includes a chronological description of the antecedents to the IEP team recommending residential placement. This narrative should minimally include specifics related to the following and should describe the efforts taken to alleviate the adverse impact of the student's disability:

- The student's educational history of initial entry into school to present time, including:
 - The types of placements the student has entered.
 - Successes and failures of the placements.
 - Reasons for any failures.
 - The student's academic strengths and weaknesses.
 - Specific description of any behavioral incidents.
 - Any other issues/concerns over the years of school enrollment and a description of actions initiated to remediate these issues/concerns.
 - The student's current levels of educational performance, including information related to functional grade level, achievement testing, or IQ testing.
 - A description of the issues, concerns, or adverse effects that led to the IEP team recommendation for residential placement.
- The student's non-educational or social history, including information on the composition of the family and any issues/concerns in the home/community.
- The student's physical health and any identified issues/concerns.
- The student's psychological or emotional health and any identified issues/concerns including information related to any psychiatric hospitalizations and resulting diagnoses or findings.
- The student's involvement with courts or other agencies.
- A description of the nature or type of program and services to be provided in the residential placement that the school district is unable to provide this student in order to ameliorate the adverse effects of the disability.

For Continuing Applications

If the student is unable to return to their home school at the time of an IEP review, there must be clearly stated specific reasons why the student cannot be educated locally. Please provide a narrative that includes the following:

- The student's current levels of educational performance, including information related to functional grade level, achievement testing results, IQ test results, etc.
- A description of the nature or type of program and services to be provided in the residential placement that the school district is unable to provide this student to ameliorate the adverse effects of the disability.
- A description of the issues, concerns, or adverse effects that necessitate the continuation of the residential placement, including specific description of the progress or lack thereof in the current placement over the previous approval period.

SECTION VII: REINTEGRATION PLAN

Private residential placement for educational reasons is considered a temporary placement. It is expected that a plan for reintegration will be made in order to accomplish a smooth transition from residential placement back into the district/community life at the appropriate time. The reintegration plan should include details as to the specific steps to be taken by the district to monitor the progress of the residentially placed student toward their eventual reintegration back to the district/community. The expectation is for the district to have monthly contacts with the facility, family, and/or student throughout their residential placement. A reintegration plan must be initiated for a student's eventual return to the district/community even though their progress in the residential facility cannot be entirely predicted. The dates the activities were carried out should be tracked by the district throughout the approval period.

DATE	PARTICIPANTS	BRIEF DESCRIPTION OF MONTHLY ACTIVITY

SECTION VIII: DOCUMENTATION OF PREVIOUS REINTEGRATION ACTIVITIES – CONTINUING APPLICATIONS ONLY

Districts applying for continuing reimbursement are required to complete the following chart documenting the dates the reintegration activities from the previous 34-37 application occurred.

DATE	PARTICIPANTS	BRIEF DESCRIPTION OF MONTHLY ACTIVITY

SECTION IX: ASSURANCES

This form must be signed by both the superintendent of the school district where the student's parent or guardian resides and the state-approved director of special education responsible for the district. Signing the form attests to the accuracy and validity of the information contained within the application and attests to compliance with the requirements of Article 14 of the School Code, ensuring that a full and comprehensive continuum of educational services is available in the district/joint agreement/region, yet is insufficient for this student's education.

We, the undersigned, do hereby declare that the foregoing statements are true to the best of our knowledge and belief, and that said school district or joint agreement has complied with requirements of the law and regulations as set forth in Article 14 of the School Code and 23 Illinois Administrative Code 226, and all other applicable state and federal laws and regulations. The costs of the placement (i.e., the tuition, room and board, and transportation as delineated in the IEP) will be paid by the district and will be at no cost to the parent or youth.

NAME OF DISTRICT SUPERINTENDENT (Please type or print the name.)	TELEPHONE NUMBER (Include Area Code.)
ADDRESS (Street, City, ZIP Code)	EMAIL ADDRESS

DATE

SIGNATURE OF DISTRICT SUPERINTENDENT

NAME OF STATE-APPROVED DIRECTOR OF SPECIAL EDUCATION (Please type or print the name.)	TELEPHONE NUMBER (Include Area Code).
IF A MEMBER OF A JOINT AGREEMENT/SPECIAL EDUCATION COOPERATIVE, NAME OF COOPERATIVE	
ADDRESS (Street, City, ZIP Code)	EMAIL ADDRESS

DATE

SIGNATURE OF STATE-APPROVED DIRECTOR OF SPECIAL EDUCATION