CENTER FOR SPECIAL SERVICES • 1606 Old Orchard Street, White Plains, New York 10604 • (914) 948-7271 • fax (914) 948-7598

ASSESSMENT/EVALUATION REQUESTFORM • 2024–2025

	Request Date:	
		Title
CASE CONTACT:		Phone:
*The case contact is the district point person designated to setting up appointments, providing reports, IEPs and other		E-Mail:
Please Check One: INITIAL EVAL	LUATION	RE-EVALUATION
STUDENT NAME:	GRADE:	: AGE: DOB:
Parent/Guardian:	Home Telephone	e or Cell:
E-Mail:	Work Telephone:	:
LOCATION: Home School Provide specifics in the space below, including FULL na Otherwise instruct the provider to call the Case Contact for	ame of school, address of sc	Hybrid school/home, and/or remote information.
*Please provide the <u>latest</u> date Evaluation ca	an be submitted:	
Select Evaluation(s) from the Dropdown Men	nu:	***If you would like the evaluator to attend the CSE Meeting/Program Review, indicate all information below (date, time, location):
Please check appropriate statement - provide consen ☐ Parental Consent Form Attached		confirm that consent is on file fied of this request; consent is on file at School District Office