**Student Add/Update Page**
**Case Manger: _________________________ Date: _______________________**

| **Initial Verification Information** | | | |
|---|---|---|---|
| Is this an initial Early Intervention or Special Education according to 92 NAC 51 (Rule 51)?<br>☐ YES<br>☐ NO | | | |
| Date the child was initially verified according to Nebraska 92 NAC 51 (Rule 51)? MM/DD/YYYY: | | | |
| Disability category the child was INITIALLY verified in Nebraska.<br>☐ Autism<br>☐ Behavioral Disorder<br>☐ Deaf-Blindness<br>☐ Developmental Delay<br>☐ Hearing Impairments<br>☐ Mental Handicap<br>☐ Multiple Impairments<br>☐ Orthopedic Impairments<br>☐ Other Health Impairments<br>☐ Specific Learning Disabilities<br>☐ Speech-Language Impairments<br>☐ Traumatic Brain Injury<br>☐ Visual Impairments | | | |
| Student ID (NDE Identifier): | | | |
| **Identifying Information** | | | |
| Name of Child (Last, First, MI): | | | |
| Birth Date of Child (MM/DD/YYYY) | | | |
| Resident School Name: | | Resident County/District/School # | |
| Gender: ☐ Male<br>☐ Female | | | |
| Race/Ethnicity (Select only one):<br>☐ White, Not Hispanic<br>☐ Black, Not Hispanic<br>☐ Hispanic<br>☐ American Indian/Alaskan Native<br>☐ Asian/Pacific Islander | | | |
| Does the child attend a Non-Public School? ☐ Yes<br>☐ No | | | |
| Is the child a Ward of the State or Court? ☐ Yes<br>☐ No | | | |
| Has a surrogate parent been appointed for this child? ☐ Yes<br>☐ No<br>If no surrogate: ☐ Not needed, parent involved ☐ Other reason, please specify: ______________________ | | | |

| Is the student limited English proficient (LEP)? | ☐ Yes<br>☐ No |
|---|---|
| Student's Grade Level:<br>☐ Pre-Kindergarten<br>☐ Kindergarten<br>☐ Grade 1<br>☐ Grade 2<br>☐ Grade 3<br>☐ Grade 4<br>☐ Grade 5 | ☐ Grade 6<br>☐ Grade 7<br>☐ Grade 8<br>☐ Grade 9<br>☐ Grade 10<br>☐ Grade 11<br>☐ Grade 12<br>☐ Grade 12 + |
| **Verifying Disability** | |
| Report the verified disability for this child, documented in the Multidisciplinary Team Report (MDT).<br><br>If Multiple Impairments selected, go to next column.<br><br>If Deaf-Blindness, Hearing Impaired or Visual Impairment, go to second column. | **(Select only one code)**<br>☐ Autism<br>☐ Behavioral Disorder<br>☐ Deaf-Blindness<br>☐ Developmental Delay<br>☐ Hearing Impairments<br>☐ Mental Handicap<br>☐ Multiple Impairment<br>☐ Orthopedic Impairments<br>☐ Other Health Impairments<br>☐ Specific Learning Disabilities<br>☐ Speech-Language Impairments<br>☐ Traumatic Brain Injury<br>☐ Visual Impairments |
| If the child is verified with multiple impairments, select whether the following disabilities are documented in the MDT report. | ☐ Hearing Impairments<br>☐ Visual Impairments<br>☐ None of the above |
| If you have indicated the child is verified with one of the following disabilities:<br>**Deaf-Blindness:** Select one item from each of the following lists for Deaf-Blindness:<br>☐ Deaf (Severe/Profound)<br>☐ Hard of Hearing (Mild/Moderate)<br>**AND**<br>☐ Blind<br>☐ Legally Blind<br>☐ Partially Sighted<br>**Hearing Impaired:** Select one item from below:<br>☐ Deaf (Severe/Profound)<br>☐ Hard of Hearing (Mild/Moderate)<br>**Visually Impaired:** Select one item from below:<br>☐ Blind<br>☐ Legally Blind<br>☐ Partially Sighted | |

| **Program Provider** | |
|---|---|
| Child receives “the majority of services” in Early Intervention, Early Childhood Special Education, Special Education and Related Services From: | **Select one below:**<br>☐ Resident District<br>☐ Another District<br>☐ Other Provider<br>If another district or other provider, please indicate them below.<br><br>CoDist #/Provider #: ________________________________<br><br>Name of District/Name of Provider<br>________________________________ |

| **Setting** | |
|---|---|
| Please indicate below where the student receives “the majority of services” (Early Intervention, Early Childhood Special Education, Special Education and Related Services) based on the child’s age. (Enter only one setting below) | |
| **Birth through Age 2** | ☐ Program Designed for Children with Developmental Delay or Disabilities<br>☐ Program Designed for Typically Developing Children<br>☐ Home<br>☐ Hospital<br>☐ Residential Facility<br>☐ Service Provider Location (outpatient facility, clinic)<br>☐ Other |
| **Ages 3 through 5** | ☐ Early Childhood Setting<br>(e.g., Head Start, childcare center, family childcare home)<br>☐ Early Childhood Special Education Setting<br>(Separate classroom for children with disabilities)<br>☐ Part-Time Early Childhood/Part-Time Early Childhood Special Education<br>☐ Home<br>☐ Hospital<br>☐ Residential Facility<br>☐ Separate School Facility<br>☐ Public School Kindergarten |
| **Ages 6 through 21** | ☐ Public School<br>☐ Public Separate Facility<br>☐ Public Residential Facility<br>☐ Private Separate Facility<br>☐ Private Residential Facility<br>☐ Home<br>☐ Hospital<br>☐ Correctional or Detention Facility |

| Check all services that apply to the Special Education and Related Services the child is currently receiving.<br><br>☐ Assistive Technology Services/Devices<br>☐ Audiology<br>☐ Family Training, Counseling, Home Visits and Other Support<br>☐ Health Services<br>☐ Medical Services (for diagnostic or evaluation purposes)<br>☐ Nursing Services<br>☐ Nutrition Services<br>☐ Occupational Therapy Services<br>☐ Physical Therapy<br>☐ Sign Language Interpreter<br>☐ Psychological Services<br>☐ Respite Care<br>☐ Services Coordination<br>☐ Social Work Services<br>☐ Special Instruction/Resource/Deaf Education<br>☐ Speech-Language Therapy<br>☐ Transportation<br>☐ Vision Services<br>☐ Extended School Year (only applicable to children 3 or older) __________________<br>☐ Other, please specify: ___________________________________________________ | |
|---|---|
| Record the percent of time the student receives Special Education and Related Services. | ____% Special Education<br>____% Special Education and Related Services with General Education Peers<br>____% General Education |

Date Entered @ CO ______________________