



PARENT INFORMATION CENTER OF DELAWARE

Request for Appointment of an EDUCATIONAL SURROGATE PARENT Referral Form



CHILD DEVELOPMENT WATCH (for children ages birth to three years old)

I am requesting that an Educational Surrogate Parent (ESP) be appointed for a child who receives, or may be in need of, special education and related services as mandated by the Individuals with Disabilities Education Act (federal law) and the Delaware State Special Education Regulations (Title 14, Chapter 31). Note: An ESP is appointed by the DE Dept. of Education (DOE) after an individual participates in training with PIC and is recommended by PIC to DOE to be an ESP for a child. I certify that the statements made in this request are true and correct to the best of my knowledge.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

DFS worker (if not the same as listed above): \_\_\_\_\_

\*\*\*CHILD INFORMATION \* CHILD INFORMATION \* CHILD INFORMATION \* CHILD INFORMATION \*\*\*

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Attorney GAL Name \_\_\_\_\_ Email address \_\_\_\_\_

CASA Name \_\_\_\_\_ Email address \_\_\_\_\_

RESIDENCE: If living with foster parent, is foster parent interested in being the child's educational surrogate parent? \_\_\_\_\_

Foster Parent/Facility \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

\*\*\*\*\*PLEASE INDICATE CURRENT OR PROPOSED ACTION\*\*\*\*\*

Child Development Watch services

\_\_\_\_ Permission to evaluate for CDW eligibility \_\_\_\_\_ Participation in IFSP planning/meeting

CDW Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Services that involve a school district:

\_\_\_\_ Permission to evaluate for special education services \_\_\_\_\_ Transition meeting with CDW and school district

\_\_\_\_ Participate in eligibility/IEP meeting

For services involving a school district, please provide the following information:

School District: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Reason for Referral:

Mother Father

- Termination of Parental Rights
Agency, after making reasonable efforts, cannot locate a parent
Parent cannot be identified
Parent whereabouts unknown
Child is in the custody of a public welfare agency (DFS, DSCYF)
Child is an unaccompanied homeless youth under McKinney-Vento

Email this form to:
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