



Short-Term Options for Assessment & Recommendations Center

57 Orchard Street, Marlborough, MA 01752 Telephone: 508-481-3611 Fax: 508-481-0379

SY 2021-2022

Dear District Special Education Administrator,

Thank you for considering SOAR as an option for your student who has diagnostic/assessment or interim placement needs. SOAR has developed the following referral, intake and follow up process to ensure that we begin programming with as much information and direction as possible to foster a timely and thorough response to your need for diagnostic or consultative information and recommendations.

Referral Process:

1. Complete **SOAR REFERRAL QUESTIONNAIRE** (pg. 2-3) and **SOAR REFERRAL CHECKLIST** (pg. 4)

2. Submit relevant documentation including but not limited to the following:

- | | |
|--|---|
| <input type="checkbox"/> IEP or 504 Plan | <input type="checkbox"/> Educational Reports |
| <input type="checkbox"/> Neuropsychological and/or Psychological Reports | <input type="checkbox"/> Psychiatric Reports |
| <input type="checkbox"/> Occupational and/or Physical Therapy Reports | <input type="checkbox"/> Consultative Reports |
| <input type="checkbox"/> Speech/Language Report | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Current MCAS Scores | <input type="checkbox"/> Other _____ |

3. Submit via email, fax, or mail the **SOAR REFERRAL QUESTIONNAIRE** and **SOAR REFERRAL CHECKLIST** along with all relevant documentation (listed above) to:

Brenda Goodreau at bgoodreau@avcollaborative.org

57 Orchard Street Marlboro, MA 01752, 508-481-3611 ext. *7015; 774-245-8996

4. Upon receiving the completed referral packet SOAR staff will review the documents and contact you with follow up questions.

5. SOAR staff will schedule an intake meeting/tour with the student/parent(s)/guardian(s) if SOAR is deemed an appropriate placement. (Please note that if a secure or restraint-based setting is needed, SOAR is not an appropriate assessment or interim placement.)

6. SOAR staff will contact the district to secure signed consent/placement page, immunization records, and transportation.

7. A start date will be determined when necessary documents and information are received.



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SOAR Referral Questionnaire

DATE OF REFERRAL: _____ **SCHOOL DISTRICT:** _____

STUDENT NAME: _____ **AGE:** _____ **GRADE:** _____

SASID #: _____ **D.O.B.:** _____

PARENT NAME AND CONTACT INFORMATION (Phone, email): _____

REFERRAL INFORMATION

Person making the referral _____

Title _____

Contact Information (email & phone #): _____

Reason for referral:



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QUESTIONS TO BE ANSWERED BY ASSESSMENT

A large, empty rectangular box with a black border, intended for the assessment questions.



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SOAR REFERRAL CHECKLIST 2021-2022

Accept and AVC member Districts	Non-Members
<u>Member rate (High School): \$14,468.60</u> <u>Member rate (Middle School): \$15,367.95</u>	<u>Non-Member Rate (High School): \$16,494.62</u> <u>Non-Member Rate (Middle School): \$17,519.40</u>

Assessment Packages:

<i>A. Standard SOAR Services (All services below included in placement)</i>	<i>B. Select SOAR Services Two (2) services included in placement. Please check those requested.</i>	<i>C. Supplemental SOAR Services</i>
<input checked="" type="checkbox"/> Academic Services (tutoring, small group, electives, specials) <input checked="" type="checkbox"/> Clinical services – individual, group, and/or dyad approaches <input checked="" type="checkbox"/> Comprehensive Case/File Review <input checked="" type="checkbox"/> Clinical Interview/ Observational Report <input checked="" type="checkbox"/> Academic, Behavioral & Observational Report	<input type="checkbox"/> Social Emotional Assessment <input type="checkbox"/> FBA & BSP- Functional Behavioral Assessment & Behavior Support Plan <input type="checkbox"/> Vocational Assessment (approx. 7 hours) <input type="checkbox"/> Speech/Language Evaluation (approx. 7 hours) <input type="checkbox"/> OT Evaluation (approx. 7 hours) <input type="checkbox"/> PT Evaluation (approx. 7 hours)	<input type="checkbox"/> Comprehensive Risk Assessment (\$1,320) <input type="checkbox"/> Fire Setting <input type="checkbox"/> Violence <input type="checkbox"/> Sexual Offending <input type="checkbox"/> Cognitive Evaluation (\$440) <input type="checkbox"/> Achievement/Academic -Full Battery(\$660) <input type="checkbox"/> Minnesota Multiphasic Personality Inventory- MMPI A (\$880) <input type="checkbox"/> Psychiatric Consult- AVC (\$273.50 per hour)
Total estimate for placement 45 days X \$321.52 = \$14,468.60 (member Rate HS) Total estimate for placement 45 days X \$341.51 = \$15,367.95 (member Rate MS)	(first 2 items included in placement)	
Total estimate for placement 45 days X \$366.551 = \$16,494.62 (non-member Rate HS) Total estimate for placement 45 days X \$389.32 = \$17,519.40 (non-member Rate MS)	Services exceeding 2, will be invoiced at \$95.35 (member) or \$108.70 (non-member) X hours per additional service <i>Total estimated additional cost:</i> _____	All supplemental Evaluation(s) priced as noted above. <i>Total estimated additional cost:</i> _____

Student Name: _____

District Name: _____

Total Estimated Cost: _____ Purchase Order #: _____

Special Education Administrator Signature

Date