

**CHEBOYGAN-OTSEGO-PRESQUE ISLE
EDUCATIONAL SERVICE DISTRICT
6065 Learning Lane
Indian River, Michigan 49749
PHONE: 231/238-9394**

EVALUATION REIMBURSEMENT FOR INITIAL AND COMPREHENSIVE RE-EVALUATION

Child's Name _____ Birthdate _____ Current Date _____

Parent/Guardian Name _____ Evaluation Date _____

Address _____

Type of Evaluation Conducted
(check one)
H.I. _____ V.I. _____
O.H.I. _____ P.I. _____
T.B.I. _____ Other _____

Telephone: _____

The following documentation must accompany this information sheet:

- (1) Copy of evaluation cost statement.
- (2) Copy of statement from other agencies or insurance company providing funding (i.e., Michigan Children's Special Health Care Services, Medicaid, personal insurance).
- (3) Round trip miles from your home to the designated site: _____

I hereby certify that the above account is true and correct and that no part of the same has been paid.

(Parent Signature) Social Security Number _____

(To be completed by the ESD)

Total Cost of the evaluation	\$ _____	Statement:	_____ Yes	_____ No
Agency Reimbursement	\$ _____	Statement:	_____ Yes	_____ No
Insurance Reimbursement	\$ _____	Statement:	_____ Yes	_____ No
Cost Not Covered	\$ _____			
Plus Total Mileage _____	+ \$ _____			
Equals:	\$ _____			(The total excess cost reimbursed to parent)

Costs submitted to other agency.
Pay transportation cost (report attached)

Cost not eligible for reimbursement by another agency. Pay transportation and evaluation costs. (Statement attached)

Signature _____
(MET Member)

Signature _____
COP ESD Supervisor

Original: COP ESD Student File

Copy: COP ESD Supervisor

Parent

SpE-3
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