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 Handicap 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.

____________________ Social Security Number __________
(Parent Signature)

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(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

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