EXCEPTIONAL SC

EXCEPTIONAL SC THIRD PARTY DESIGNATION PROOF OF ELIGIBILITY MEDICAL/PROFESSIONAL FORM

43-243.1. Criteria for Entry into Programs of Special Education for Students with Disabilities.

A. General Requirements

These criteria for entry into programs of special education for students with disabilities will be used by all members of the multidisciplinary team, who may include school psychologists, speech-language therapists, and other persons responsible for the identification and evaluation of students with disabilities.

Categories of disabilities as defined in 43-243.1:

- autism
- deafness and hearing impairment
- deafblindness
- emotional disability
- mental disability
- multiple disabilities
- orthopedic impairment
- other health impairment
- specific learning disability
- speech or language impairment
- traumatic brain injury
- visual impairment

This form should be completed by a licensed medical professional. Upload and attach the completed form to the Exceptional SC online application.

Please note: Beginning with the 2018-2019 application year, we will only accept the Exceptional SC medical/professional form. Forms previously used by former SFOs will no longer be accepted.

Student's Full Legal Name: _____ Date of Birth:_____

South Carolina Exceptional Needs Children's Fund Act 247 defines an "exceptional needs child" as a child:

(a) who has been evaluated in accordance with this state's evaluation criteria, as set forth in S.C. Code Ann. Regs. 43-243.1, and determined eligible as a child with a disability who needs special education and related services, in accordance with the requirements of Section 300.8 of the Individuals with Disabilities Education Act; **or**

(b) who has been diagnosed within the last three years by a licensed speech-language pathologist, psychiatrist, or medical, mental health, psychoeducational, or other comparable licensed health care provider as having a neurodevelopmental disorder, a substantial sensory or physical impairment such as deaf, blind, or orthopedic disability, or some other disability or acute or chronic condition that significantly impedes the student's ability to learn and succeed in school without specialized instructional and associated supports and services tailored to the child's unique needs.

By signing below, I am affirming:

1. I am a licensed speech-language pathologist, psychiatrist, or medical, mental health, psychoeducational, or other comparable licensed health care provider.

   Licensed health care provider type: _____

2. I diagnosed the above named student on _____ (most recent date within three years) as having a neurodevelopmental disorder, a substantial sensory or physical impairment (deaf, blind, or orthopedic disability), or some other disability or acute or chronic condition that significantly impedes the student's ability to learn and succeed in school without specialized instructional and associated supports and services tailored to the student's unique needs.

   Disability type: _____

   Additional notes or details (optional): _____

   _____

   _____

_____ _____

PROFESSIONAL'S NAME (PRINT) TITLE

_____ _____

PROFESSIONAL'S SIGNATURE DATE