**Smart Choice Therapy Inc**

Preschool Special Education & Multidisciplinary Evaluation Program

1250 Hylan Blvd, Suite 9B, Staten Island, NY 10305

Phone: (718) 414-2596 Fax: (929) 274-7419

**PARENT INTRODUCTION LETTER**

**Student’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student’s NYC ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dear Parent/Guardian:

Please allow me to introduce myself. My name is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

My phone is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I am the professional who will be providing SEIT (Special Education Itinerant Teacher) services to your child according to the goals and mandates identified on your child’s Individualized Educational Program (IEP).

SEIT IEP Mandate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ] Individual Session [ ] Group Session (indicate size of group) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of Service Provision: [ ] Home [ ] School (indicate name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If I am providing services at your child’s school, as part of regulations for CPSE service provision, I will consult with the classroom teacher so that we work together on following the goals identified in your child’s IEP. Collaboration with the regular education teacher will ensure your child’s progress in the school setting. Please note that only the parent/guardian can provide IEP documentation including written progress reports, session notes or other confidential information to the school and/or the school teacher. If you would like for me or Smart Choice Therapy Inc. to provide school with such information, you must sign a written consent for release of information

Listed below is the schedule that has been arranged for service provision either in your home or at the child’s school. Times of the sessions are noted in the table below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
|  |  |  |  |  |  |
|  | **Services cannot be provided before 8:00 am or after 6:00 pm as well as on weekends or legal holidays.** |

If you have any questions or concerns, please do not hesitate to contact Smart Choice Therapy Inc at (718) 414-2596. I look forward to working with you and your child to assure academic readiness and full learning potential for your child as outlined on the IEP.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider's name and title Date

***Within 48 hours from the start of services, please submit the completed copy to Smart Choice Therapy Inc.***