

**RICHMOND COUNTY SCHOOL SYSTEM—TITLE I
REQUEST FOR SUPPLEMENTAL EDUCATIONAL SERVICES**

FREE TUTORING

This form must be returned to the Title I Office, 864 Broad Street, 1st Floor, Augusta, Georgia 30901 or faxed to (706) 826-4652, Attention: Mrs. Stallings, Title I Director. **REPLY BEFORE Friday, November 20, 2009.**

Yes, I would like for my child to receive Supplemental Educational Services.

No, I would not like for my child to receive Supplemental Educational Services.

PLEASE PRINT

Student's Name: _____

Address: _____

City: _____ Zip Code: _____

Telephone Numbers: Home _____ Evening: _____ Cell _____

Student's School: _____

Student's Grade: _____ Teacher: _____

Date of Birth: _____ Gender: Male Female

Math Reading/Language Arts English Other subject (High School) _____

I am requesting Supplemental Educational Services for the student named above. I have been informed and understand that the Richmond County School System (RCSS) cannot at this time guarantee that the requested provider can or will provide the requested services, although the RCSS will make every effort to honor my request. If my first choice provider is unable to provide services, my child will automatically be placed with the second or third choice provider listed below. I understand if my child cannot be placed with the preferred SES provider, the RCSS will contact me to select another provider. I also understand that the school system is not responsible for providing transportation to and from these services and the amount of money the school district may spend on Supplemental Educational Services for any student during the current school year is limited by law. Tutoring is limited to four hours per week. I authorize the school district to release my child's assessment data to the selected provider in an effort to assist them in developing a tutorial program that addresses the specific needs of my child.

Name of Requested Provider: (See Supplemental Educational Services Provider Directory) **MUST SELECT 3**

FIRST CHOICE: _____

SECOND CHOICE: _____

THIRD CHOICE: _____

Parent's Name: (PLEASE PRINT) _____

Parent's Signature: _____ Date: _____

District Office Use ONLY

Early Intervention Program (EIP)
Limited English Proficiency (LEP)
Students with Disabilities (SWD)

Student ID # _____
Date Received _____

Approved
Not Approved

Eligible for Free/Reduced Meals: Yes No