

**MASSACHUSETTS DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION**



**SPECIAL EDUCATION  
SURROGATE PARENT APPLICATION**



**A. VOLUNTEER INFORMATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (Initial)

Address: \_\_\_\_\_  
(No./Street) (City/Town) (State) (Zip)

Telephone: \_\_\_\_\_  
(Day) (Evening)

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
*(For SESP Program use only)*

**How do you prefer to be contacted?**  Day Phone  Eve Phone  Cell Phone  Email

**How did you hear about the Special Education Surrogate Parent (SESP) Program?** \_\_\_\_\_

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

**Why are you interested in becoming a Special Education Surrogate Parent?** \_\_\_\_\_

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

**Are you or your spouse employed by any public or private agency (including school systems) involved with the care or education of children?**

Yes  No Please list: \_\_\_\_\_

\_\_\_\_\_

**Do you speak any languages other than English?**  Yes  No

Please list: \_\_\_\_\_

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**B. STUDENT INFORMATION**

**Are you applying to become an SESP for a specific child?**

- Yes (complete this section)       No (skip to Section "C")

If yes, child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**What is your relationship to the child?**

- Visiting Resource     GAL     Relative     Other: (Please explain)
- 

**Would you be willing to serve as an SESP for other children?**  Yes  No

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**C. PREFERENCES**

**Would you prefer a match with a child in a particular age group?**

- No preference       Age 3-6       Age 7-12       Age 13-16       Age 17-22

**Would you be willing to serve as an SESP for more than one child at a time?**

- Yes     No     Not sure

**Please check the type(s) of disabilities in which you have the most experience or interest:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> No particular preference      | <input type="checkbox"/> Autism                              | <input type="checkbox"/> Developmental delay |
| <input type="checkbox"/> Intellectual                  | <input type="checkbox"/> Sensory: Hearing, Vision, Deafblind | <input type="checkbox"/> Neurological        |
| <input type="checkbox"/> Emotional                     | <input type="checkbox"/> Communication                       | <input type="checkbox"/> Physical            |
| <input type="checkbox"/> Specific Learning             | <input type="checkbox"/> Health                              |  |
| <input type="checkbox"/> Other (please specify): _____ |  |  |

**Please list the names of cities/towns where you are willing to volunteer.**

- |          |           |
|----------|-----------|
| 1) _____ | 6) _____  |
| 2) _____ | 7) _____  |
| 3) _____ | 8) _____  |
| 4) _____ | 9) _____  |
| 5) _____ | 10) _____ |

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**D. SPECIAL EDUCATION EXPERIENCE**

**Are you the parent or relative of a child with special education needs?**

Yes  No

**Have you ever attended a Team meeting for a child?**

Yes  No

**Have you ever signed an Individualized Education Program (IEP) as the parent or guardian of a child?**

Yes  No

**Have you had any training or experience with the special education process?**

Yes  No

Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Is there any other information about yourself that you want to provide for this application?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list *two persons* as references. One work or volunteer work related, and one personal (not a family member) is best:**

<b>1</b>	<hr/> <p>Name</p> <hr/> <p>Company Name</p> <hr/> <p>Address</p> <hr/> <p>City/State/Zip</p> <hr/> <p>Telephone #</p> <hr/> <p>Email</p>	<b>2</b>	<hr/> <p>Name</p> <hr/> <p>Company Name</p> <hr/> <p>Address</p> <hr/> <p>City/State/Zip</p> <hr/> <p>Telephone #</p> <hr/> <p>Email</p>
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I hereby grant permission to the Department of Elementary and Secondary Education/EDCO Collaborative to check my references and to conduct a Criminal Offender Record Information (CORI) check.

I understand that my application does not guarantee my appointment as a volunteer Special Education Surrogate Parent. I also understand that I must receive training, as requested to be appointed as a Special Education Surrogate Parent. If appointed, I will protect the confidentiality of all information regarding students I represent in special education matters.

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(Signature)

(Date)

**Please be sure you have:**

- Signed the application**
- Provided two references**

*Please return this completed application to:*

**Special Education  
Surrogate Parent Program  
P.O. Box 1184  
Westboro, MA 01581**

**Phone: 508-792-7679**

**Fax: 508-616-0318**

**Email: [sespp@earthlink.net](mailto:sespp@earthlink.net)**

**Thank You!**

**Visit us online:**

**[www.sespprogram.org](http://www.sespprogram.org)**