Instructional Services Department

RECLASSIFICATION REQUEST FORM - Grades 6th – 8th

School____ **Date**____________
Student Name___________________________________ **I.D. #**______________________ **Grade**________
Date of Birth___________________ **Primary Language**________________

1. Assessment of English Language Proficiency:

A student must meet the threshold score per their grade level indicated in the table below in the Overall section of the English Language Assessment for California Test (ELPAC).In addition, their Oral Language score and their Written Language score must be Level (3) or higher.

Overall ELPAC Score	Scale score
5th 1514 or above	
6th -7th -8th 1532 or above	

Oral Language Score	Level	3	4
Written Language Score	Level	3	4

Circle one for each area:

ELPAC 's Date:_________________

☐ This student was assessed with an Alternate Assessment and scored proficient in this language assessment instrument

2. Basic Skills in English Language Arts:

English Language Arts (ELA) Students must meet one of the following: **(Scale scores are from previous grade SBAC assessment)**

- ☐ **SBAC ELA Standard Nearly Met at;**
  - **6th Grade Scale Score of 2471 or above** **Level: ______ Score: ________**
  - **7th Grade Scale Score of 2493 or above**
  - **8th Grade Scale Score of 2515 or above**
- ☐ **DORA: 6th Grade C,G,H:_____**
- ☐ **GPA 2.0 or above** **GPA: ______**
- ☐ **65% or above in the multiple-choice portion of two ELA unit assessments; OR**
  Unit: _______Score: ________ Unit: _______Score: ________

3. Teacher Evaluation: (Deficits in motivation and academic success NOT related to English Language Proficiency do not prevent a student from reclassification.)

Based on the information on this form, is this student recommended for reclassification? Yes/ No
If he/she is not, please explain why and provide evidence. ____
____
Teacher Name: ____________________________ Signature: ____________________________ Date: ___________

4. Parental opinion and consultation:

Parent____ Date___________________________
Parent Meeting Date: ______________________________________
Per Letter_____ Per Phone Call _____ Spoke to______________ Date__________ Time__________

RECOMMENDED FOR RECLASSIFICATION

Yes/No _____ Date: ___________ Request Initiated by: ____
(Name) (Title)

☐ SST/Parent Conference: Yes/No Date: _______ ☐ Hearing/Vision screening: Pass/No Pass

If the student does not meet reclassification criteria, an intervention must be provided: Suggestions for Interventions below

☐ **Academic Contract/Student Conference**	☐ **Sat./before/after school Language Devlp. Intervention**
☐ **Sat./before/after school Academic Support**	☐ **Other: Specify______________________________**

Collect evidence of intervention when provided for submission at the end of the intervention.

Principal or Designee_______________________________________ **Date**_________________