

WCSSSD

Warren County Special Services School District

Joseph E. Flynn ~ Superintendent

CONTRACTED SERVICES REQUEST FORM

Please complete a separate form for each service you are requesting. Place an X next to the desired service. Supply all related information as requested. Refer to current fee schedule.
Fax: 908-223-7314 or email (s.okeefe@wcsssd.org) or mail to WCSSSD.

DATE: _____ CONTACT PERSON: _____ TEL.# _____ Ext. _____

CONTACT PERSON EMAIL ADDRESS: _____ FAX# _____
(PLEASE PRINT LEGIBLY)

The _____ School District would like to request the following Contracted Service from the Warren County Special Services School District. The _____ School District is to be billed for this service.

CHILD STUDY TEAM SERVICES

Psychologist _____ Social Worker _____ Learning Consultant _____
Full Time _____ Part Time _____ Per Case/Hourly _____
Case Management _____ Evaluation _____ Student Name _____
Attend Meeting _____ Record Review _____
Date by Which Evaluation Report is Needed: _____
Begin Date _____ End Date _____
Location of Services _____
Student Hours _____ Staff Hours _____

INSTRUCTIONAL PERSONNEL

Teacher _____ Classroom Aide _____ Personal Aide _____
Student Name _____ DOB _____ Full Time _____ Part Time _____ Per Diem _____
Substitute _____
Begin Date _____ End Date _____ Type of Class/Program _____
Location of Services _____
Student Hours _____ Staff Hours _____

**Please attach a description of the student or classroom setting in which the staff member will be working; Include cognitive abilities, toileting/lifting needs, age, etc.

RELATED SERVICES

Speech Therapy _____ PT _____ OT _____ Counseling _____ Augmentative Communication Evaluation _____
ABA _____
Full Time _____ Part Time _____ Short Term Substitute Basis _____
Evaluation _____ Case Management _____
Direct Services _____ Student Name _____ DOB _____
(Attach current IEP and PT Rx, if applicable.)

Date by Which Evaluation Report is Needed: _____

Begin Date _____ End Date _____ Duration of Treatment _____
Location of Services _____
Student Hours _____ Staff Hours _____

Signature Authorizing Agent _____ Date _____

OFFICE USE: Date Service Secured: _____ Service Provider: _____