WCSSSD *Warren County Special Services School District*

Joseph E. Flynn ~ Superintendent

Please complete a separate form for each service you are requesting. Supply all related information as requested. Refer to current fee schedule. Fax: 908-223-7314 or mailto:s.okeefe@wcsssd
or mail to WCSSSD, 682 Oxford Road, Oxford, NJ

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_____ Re- Evaluation_____
Attend Meeting_____ Record Review_____
Student Name_____ **DOB**_____

Begin Date_____ End Date_____
Location of Services_____
Student Hours _____ Staff Hours _____
Date by Which Evaluation Report is Needed:_____

Reason for Referral:_____

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_____
(FBA,_____Behavioral Observation_____Behavioral Plan_____
_____
Full Time_____ Part Time_____ Short Term Substitute Basis_____
Evaluation_____ Case Management_____
Direct Services _____ **Student Name**_____ **DOB**_____
(Attach current IEP and PT Rx, if applicable.)
Reason for Referral:_____
_____

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: _____