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: ______________________