

WCSSSD Warren County Special Services School District

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.org](mailto:s.okeefe@wcsssd.org); e.santos@wcsssd.org

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

CONTACT PERSON EMAIL ADDRESS: _____

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: _____

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 _____

Begin Date _____ End Date _____ Duration of Treatment _____

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.

Signature Authorizing Agent _____ Date _____

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