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3rd Floor
Paramus, NJ 07652

201-343-6000 x 6541

BERGEN COUNTY
Special Services School District
EST. 1971

Michele Griffin
201-291-0492
www.bergen.org/ee

REQUEST FOR SERVICES

** ALL CONTRACTS END JUNE 30TH – A NEW FORM IS REQUIRED IN THE SPRING FOR SUMMER CONTRACTS**

1. PERIOD ☐ SEPTEMBER 2018-JUNE 2019 ☒ JULY 2019 ☐ JULY–AUGUST 2019 ☐ SEPTEMBER 2019-2020

2. SERVICE INFORMATION (STUDENT SERVICES) **PLEASE COMPLETE ELECTRONICALLY USING ADOBE ACROBAT OR PRINT LEGIBLY**

STUDENT NAME:_____ AGE:_____ DOB:_____ GRADE:_____

PARENT'S NAME(S):_____ PHONE:_____ MAY WE CONTACT PARENT(S) ☐ YES ☐ NO

HOME ADDRESS:_____

SCHOOL STUDENT ATTENDS:_____ SCHOOL PHONE NUMBER:_____

SCHOOL ADDRESS:_____

CLASSIFICATION:_____ OR ☐ N/A

CASE MANAGER'S NAME:_____ PHONE:_____ EMAIL:_____

MAILING ADDRESS:_____

CONTACT PERSON TO SCHEDULE APPOINTMENT:_____PHONE:_____

CONTACT PERSON EMAIL:_____

3. THE FOLLOWING IS A REQUEST FOR: (CHECK ONE OR MORE) **FOR HEARING SERVICES-PLEASE USE SOUND SOLUTIONS REQUEST FORMS**

☐ ASSISTIVE TECHNOLOGY (SEE #4) (ACADEMIC SUPPORTS)
☐ AUGMENTATIVE COMMUNICATION (SEE #4) (COMMUNICATION SUPPORT/DEVICES)
☐ EDUCATIONAL CONSULTING SERVICES
EQUIPMENT RENTAL (SEE #6)
☐ TRANSITION/SCHOOL TO CAREERS
☐ INCLUSION/MAINSTREAMING
☐ OTHER (SPECIFY:_____

☐ PARA EDUCATOR TRAINING
☐ BEHAVIOR ANALYSIS SERVICES
☐ NON-AUTISM SERVICES
☐ ABA HOME PROGRAM/PARENT TRAINING
☐ FUNCTIONAL BEHAVIOR ASSESSMENT
☐ ABA CONSULTATION FOR STUDENT
☐ ABA STAFF TRAINING/CONSULTATION
☐ THERAPEUTIC ADVENTURE

☐ THERAPRUTIC YOGA
☐ SIGN LANGUAGE INTERPRETER
☐ FT ☐ PT
☐ RELATED SERVICES (SELECT)
☐ SPEECH ☐ OT ☐ PT
☐ CST EVALUATION (SELECT)
☐ SOCIAL ☐ EDUCATIONAL
☐ PSYCHOLOGICAL

HAVE YOU DISCUSSED THIS REQUEST WITH AN ED. ENTERPRISES STAFF PERSON? YES NO NAME:_____

4. TYPE OF SERVICE: (CHECK ONE OR MORE)

☐ EVALUATION ☐ ONGOING SERVICES FREQUENCY: #OF HOURS REQUESTED:_____ PER: WEEK ☐ MONTH ☐ YEAR ☐

☐ WORKSHOP ☐ OTHER:_____

DESCRIPTION OF SERVICE REQUESTED:_____

5. SERVICE INFORMATION-WORKSHOPS- (TO BE CONFIRMED)

TITLE OF WORKSHOP(S):_____LOCATION OF WORKSHOP(S):_____

DATE(S) OF WORKSHOP:_____ TIME OF WORKSHOP(S):_____# OF WORKSHOP PARTICIPANTS:_____

6. REPORTS AND EVALUATIONS: **SENT TO DIRECTOR OF SPECIAL SERVICES** ****MUST BE COMPLETED****

DIRECTORS FULL NAME:_____

MAILING ADDRESS:_____

7. CONTRACT INFORMATION: **SENT TO DIRECTOR OF SPECIAL SERVICES** ****MUST BE COMPLETED****

PERSON REQUESTING SERVICES:_____TITLE:_____

DISTRICT:_____ PHONE#:_____ FAX#_____ EMAIL:_____

****SEND CONTRACT TO ADMINISTRATOR:**

FULL NAME: _____ TITLE:_____ DISTRICT:_____

ADDRESS:_____

COUNTY:_____ PHONE#:_____ FAX#_____ EMAIL:_____

****AUTHORIZED BY (SIGNATURE):** _____ DATE:_____