BERGEN COUNTY SPECIAL SERVICES ~ EDUCATIONAL ENTERPRISES

540 FARVIEW AVE, 3rd FLOOR ~ PARAMUS, NJ 07652

FAX TO: Michele Griffin (201) 291-0492 ~ www.bergen.org/ee ~ (201) 343-6000 x 6541

REQUEST FOR SERVICES

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

1. PERIOD ☐ SEPTEMBER 2017 ~ JUNE 2018 ☐ JULY 2018 ☐ JULY ~ AUGUST 2018 ☐ SEPTEMBER 2018 ~ JUNE 2019

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

STUDENT'S NAME: _____ AGE: _____ DOB: _____ GRADE: _____

PARENT'S NAME(S): _____ PHONE: _____ MAY WE CONTACT PARENT(S)? ☐ Y ☐ N

HOME ADDRESS: _____

SCHOOL STUDENT ATTENDS: _____ SCHOOL PHONE #: _____

SCHOOL ADDRESS: _____

CLASSIFICATION: _____ OR ☐ N/A

CASE MANAGER'S NAME: _____ PHONE #: _____ E-MAIL: _____

MAILING ADDRESS: _____

CONTACT PERSON TO SCHEDULE APPT: _____ PHONE #: _____ E-MAIL: _____

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
☐ 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
☐ THERAPEUTIC YOGA
☐ SIGN LANGUAGE INTERPRETER ☐ FT ☐ PT
☐ RELATED SERVICES: (SELECT) ☐ SPEECH ☐ OT ☐ PT
☐ CST EVALUATION (SELECT) ☐ SOCIAL ☐ EDUCATIONAL ☐ PSYCHOLOGICAL
☐ OTHER (SPECIFY): _____

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: # 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. EQUIPMENT RENTAL:

☐ AAC DEVICE ☐ LAPTOP W/SOFTWARE ☐ PICK UP/DELIVERY/ASSEMBLY ONLY ☐ PICK UP/DELIVERY/ASSEMBLY-UP TO ONE (1) HR TRAINING

LENGTH OF RENTAL : ☐ 1 MO ☐ 2 MO ☐ 3 MO ☐ 6 MO ☐ 9 MO ☐ 10 MO ☐ 12 MO COMMENTS: _____

7. REPORTS AND EVALUATIONS: **SENT TO DIRECTOR OF SPECIAL SERVICES** ***(MUST BE COMPLETED)****

DIRECTOR'S FULL NAME: _____

MAILING ADDRESS: _____

8. CONTRACT INFORMATION ***(MUST BE COMPLETED)****

PERSON REQUESTING SERVICES: _____ TITLE: _____

DISTRICT: _____ PHONE #: _____ FAX #: _____ E-MAIL: _____

**SEND CONTRACT TO (ADMINISTRATOR):

FULL NAME: _____ TITLE: _____ DISTRICT: _____

ADDRESS: _____

COUNTY: _____ PHONE #: _____ FAX #: _____ E-MAIL: _____

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