EDUCATIONAL SERVICES UNIT

EDUCATIONAL SERVICES UNIT
Burlington County Special Services School District
20 Pioneer Blvd., Westampton, NJ 08060-3824
www.edservicesunit.com
(609) 702-0500

Dr. Christopher J. Nagy
BCSSSD/BCIT Superintendent of Schools
cnagy@burlcoschools.org
Theresa L. Margiotta
BCSSSD/BCIT Business Administrator
tmargiotta@burlcoschools.org
Bobbie M. Downs
Educational Services Unit Director
bdowns@burlcoschools.org

Deaf / Hard of Hearing Services Request Form

Student Information		**District Information**	
Student's Name:	_____	**School District:**	_____
NJ SID #:	_____	**Contact Person:**	_____
Classification:	_____	**Phone Number:**	( ) _____
DOB:	_____	**FAX Number:**	( ) _____
School Attending:	_____	**Email Address:**	_____
Grade:	_____	**Case Manager:**	_____

The following are required *for all AI Services*:

IEP: ☐ **Attached** ☐ **Will be sent separately** **Audiogram:** ☐ **Attached** ☐ **Will be sent separately**

Ongoing Services: If specific days/times are requested, every attempt will be made to accommodate.

Service	Frequency	Start/End Dates	Student Uses/Needs
☐ ***Itinerant TOD** (Teacher of the Deaf) For students requiring minimal support as skills are comparable to their same age peers. *See Service Delivery below			☐ Sign Support ☐ Spoken Language Support ☐ Total Communication
☐ ****Bridge Extension** *(in your home district)* **AM or PM Session** For students who require intense TOD support. Students are one or more years behind in comparison to their same age peers. **See Service Delivery below *Services billed at a special rate, please reference the Professional Service Agreement.*	☐ AM ☐ PM		
☐ **EI** (Educational Interpreter) *Minimum 2 hours*			
☐ **1:1 Aide with ASL Skills** (for students in grades PS-1) *Minimum 2 hours*			
☐ **D/HH Speech** *Minimum 1 hour*			

As Needed Services:

☐ **Meeting/Assembly Interpretation*** (2 hr minimum): ☐ **For Student** ☐ **For Parent/Guardian** ☐ **For Assembly**
Date(s): _____ **Location:** _____ ☐ **For Meeting (IEP, Parent Conference, etc.)**

☐ **Classroom Observation:** (6 hr minimum, includes student classroom observation, dialogue with team and recommendation report)

☐ **Cochlear Implant Rehabilitation & Education Service:** (6 hr minimum, student classroom observation, dialogue with team, recommendation and report of findings meeting)

☐ **Workshop or Consultation:** Please specify: _____ **Date(s):** _____ **Location:** _____

Comments:

**Minimum 1.0 hour (45 mins contact/15 mins to complete tasks associated with service request) and every hour thereafter will reflect the 45/15 service.*
*** 3.25 AM or PM sessions include push in/pullout service, teacher consultations, observations, and completion of tasks associated with service request.*

Signature and date below indicate approval of services requested

_____ _____
CST Director Signature **Date**

Note: Out of county school districts requesting services will incur destination charges to/from service locations outside of Burlington County.
***Requested TOD services can include: direct student support, student observations, meeting attendance, data collection, note taking, teacher/team, etc.**
District Case Manager will be contacted by the D/HH Department upon receipt of the form to confirm the request for services.
Please fax the completed form to: 609-534-2066 or email to dhand@burlcoschools.org. Questions please call: 609-702-0500 x7401