



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

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BLOCK BILL REQUEST FORM

RELATED SERVICES REQUEST INFORMATION							
<i>Block Bill applies to requests of 6.5 hours per day or 3.25 hours per half day(am or pm) of compensated time.</i>							
Please indicate number of full and half days needed per week . We will do our best to accommodate days of the week preferences.				Start Date	End Date	School Name(s)	Program Hours
Occupational Therapy	Full days # _____ Half days # _____ <input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Flexible				
Physical Therapy	Full days # _____ Half days # _____ <input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Flexible				
Speech Therapy	Full days # _____ Half days # _____ <input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Flexible				

Note: Out of county school districts requesting service/s will incur destination charges to/from service locations outside of Burlington County. CST or designee listed below will sign Monthly student service schedules. For individual requests, please submit Request for Services Form for each student. Block Billing services are in effect during months of September through June.

Please note name and title of designee, if any, approved to accept, with signature, monthly staff schedules: _____

Name and Title

CST Director/Principal: _____ Date: _____

(My signature and date indicate approval for district to be billed and that I have read and acknowledge the Related Services Billing and Program Descriptors).

EDUCATIONAL SERVICES UNIT ONLY			
Date Received: _____	Date Reviewed: _____	Accept _____	Decline _____
Notes:		Wait List _____	
Notified District: ___/___/___	By letter ___	Email ___	Phone ___
Therapist(s) Assigned: OT _____	Who: _____	Scanned _____	Filed _____
	PT: _____	SLP: _____	

Please email form to: esurelatedservices@burlicoschools.org

Any questions, please call Brooke Decker (609) 702-0500 ext. 7431