



Educational Services Unit

Burlington County Special Services School District

20 Pioneer Blvd.

Westampton, NJ 08060

www.edservicesunit.com

(609) 702-0500

Dr. Ashanti Holley
Superintendent of Schools
aholley@burlcoschools.org

Mr. Andrew Willmott
Business Administrator
awillmott@burlcoschools.org

Dr. Bobbie Downs
Assistant Superintendent
bdowns@burlcoschools.org

BLOCK BILL REQUEST FORM

RELATED SERVICES REQUEST INFORMATION
Block Bill applies to requests of 6.5 hours per day or 3.25 hours per half day(am or pm) of compensated time.

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"/> Thursday <input type="checkbox"/> Tuesday <input type="checkbox"/> Friday <input type="checkbox"/> Wednesday <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"/> Thursday <input type="checkbox"/> Tuesday <input type="checkbox"/> Friday <input type="checkbox"/> Wednesday <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"/> Thursday <input type="checkbox"/> Tuesday <input type="checkbox"/> Friday <input type="checkbox"/> Wednesday <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.

CST Director/Supervisor: _____

District: _____

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 _____ Wait List _____

Notes: _____

Notified District: ___/___/___ By letter ___ Email ___ Phone ___ Who: _____ Scanned _____ Filed _____

Therapist(s) Assigned: OT _____ PT: _____ SLP: _____

Please email form to:

esurelatedservices@burlcoschools.org