DEPARTMENT OF SPECIAL SERVICES
TOWNSHIP OF UNION PUBLIC SCHOOLS
M-E-M-O-R-A-N-D-U-M

TO: Pat Ditri

From: Kim Conti

Re: Board Agenda

Date: April 29, 2013

The committee recommends and I so move that approval be given to New Jersey Specialized Child Study Team (Katzenbach School for the Deaf) to provide Partial Evaluation Package at the rate of $1350 and Individual Evaluations at the rate of $400 per evaluation for the 2013-2014 School Year, not to exceed $4,500. (Acct. 11-000-219-320-01-19)

New Jersey Specialized Child Study Team
Evaluation Services for Students who are Deaf or Hard of Hearing
P.O. BOX 535, Trenton, New Jersey 08625-0535
609–530–3145 (V/TTY) (609)–530–3141 (FAX)

Fax Transmittal

To: Kathy

Fax #: 908 851 6881

From: ☐ ☑ Lorraine Asciutto ☐ _____

Re: _____

Date: 4/25/13 Total number of pages (including cover): 6

☑ Application packet for SCST services, as per your request.

☐ Other:

Union S/D

(Revised 2/09)

Katzenbach

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P.O. BOX 535, Trenton, New Jersey 08625-0535
609–530–3145 (Voice) (609)–530–3141 (Fax)

IMPORTANT NOTE: Your application will be held in a pending file and your student will not be scheduled for evaluation until ALL information listed below has been received.

Instructions for submission of application:

FAX the first five items on the list and include a note that the remaining items have been mailed:

or MAIL all of the listed items to the SCST at the address below.

- ☐ **Completed Data Sheet**
- ☐ **Completed Contract/Request for Service**
- ☐ **Completed district Purchase Order/Invoice (Payable to N.J. SCST)**
- ☐ **Copy of the student's most current audiological information, including an audiogram**
- ☐ **Completed SCST Release of information/Certification of Parental Notification form**
- ☐ **Current IEP**
- ☐ **Copies of most current evaluations**
- ☐ **Copy of the student's signed parental consent to test letter**

Following the processing of your application, the NJSCST will return a copy of the signed contract to you, along with a tentative date of when the evaluations will begin. If you do not hear from us within a reasonable time frame, please call to assure that your application has been received. When testing has been completed, the NJSCST will mail you the reports and recommendations.

Please send your completed application packet to:

New Jersey SCST
P.O. BOX 535
TRENTON, NJ 08625-0535
FAX: 609-530-3141

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REQUEST FOR SERVICE

PLEASE COMPLETE/SIGN ALL AREAS BELOW

Check Requested Services

☐

☐ **PARTIAL EVALUATION PACKAGE $1350**
Speech/Language
Psychological
Educational
Staffing***

***With a Full or Partial Package, NJSCST representatives will attend the student's Eligibility meeting, upon request and pending mutual scheduling availability, to present their findings.

☐ **INDIVIDUAL EVALUATIONS**

☐ Speech/Language	$400
☐ Educational	$400
☐ Psychological	$400
☐ Staffing***	$150

Total Individual Evaluation Fee: _____

***When 2 or more individual evaluations are requested, NJSCST representatives may attend the student's Eligibility meeting, upon request and pending mutual scheduling availability, to present their findings, for the additional fee listed above.

NOTE: If the NJSCST is unable to provide evaluation services, the district will be notified immediately. In this event, the contract will be voided and there will be no charge assessed to the district by the NJSCST. In instances of vacancy/absence of full time staff members, qualified consultants may be used. Contract void if funding is not allocated to support the NJSCST.

NJSCST USE ONLY

Student's Name: _____

Supervisor NJSCST **Date** **Student Case#**

ed 3/2013)

District Information:

▶ _____
Name of District

▶ _____
Phone Number

▶ _____
Address

▶ _____
City

▶ _____
State **Zip**

▶ _____
County

▶ _____
Name of Student

SIGN HERE
▼

_____
Signature of District Representative

▶ _____ _____
Name of District Representative **Date**
(please print)

▶ _____
Title of Person Authorizing Contract

NJ SPECIALIZED CHILD STUDY TEAM – DATA SHEET

INFORMATION ABOUT THE STUDENT

Name of Student: _____ Gender: ☐ Male ☐ Female ☐ Ethnicity _____

Date of Birth: _____ Age: _____ Grade: _____

Student's Classification: _____ Student's District: _____

Does the student use sign language?
☐ No ☐ Yes _____

Does the student have any medical problems?
☐ No ☐ Yes _____

Does the student wear glasses?
☐ No ☐ Yes _____

Does the student have any handicapping conditions in addition to deafness?
☐ No ☐ Yes _____

Does the student have hearing aids or a cochlear implant?
☐ No ☐ Yes Please indicate: _____

Has a Consultant been involved with this student?
☐ No ☐ Yes ☐ Karen Noble ☐ T. Sheehan ☐ Wendy Eufemia

Does the student have any visual problems?
☐ No ☐ Yes _____

INFORMATION ABOUT PARENTS/GUARDIANS

Parents / guardians: _____ Home Phone: (___) _____

Address: _____ Work Phone: (___) _____

City: _____ State: _____ Zip: _____ E-mail:

Language spoken at home: ☐ English ☐ Spanish ☐ Other: _____

INFORMATION ABOUT THE STUDENT'S SCHOOL PROGRAM

School Name: _____ School Contact: _____

Address: _____ Phone: (___) _____

Fax: _____ E-mail: _____

Type of program in which the student is enrolled:

☐ School for the Deaf ☐ Included with Interpreter ☐ Supported with itinerant teacher of the deaf
☐ Self Contained Class ☐ Included without Interpreter
☐ Other: Please describe: _____

LEA/OTHER INFORMATION

Referring District: _____ County of Residence: _____

Case Manager: _____ Title: _____ Phone: _____

Fax: _____ E-mail: _____

Reason for Referral: ☐ Initial Eligibility ☐ Re-Evaluation ☐ Other:

Describe any problems or areas of concern that you wish us to address during testing (Please be specific): _____

Services being requested: **(Note: A staffing may be added to 2 individual evaluations for an additional fee.)**

☐ **Partial Evaluation: (Speech/Language, Psychological, Educational, Staffing)**

☐ **Individual(s):** ☐ **Speech/Language** ☐ **Psychological** ☐ **Educational** ☐ **Staffing**

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Regarding (student's name): _____

Release of Information

Permission is granted by the_____ School District to release to the NJ Specialized Child Study Team all information, reports, evaluations, summaries, etc., regarding the above named student. Consultations with parents and/or professional school personnel may also be conducted to obtain their impression of the student. The evaluators are also given permission to check the student's audiological equipment to ensure its optimum performance prior to the initiation of testing. All information will be used in professional confidence, in the interest of the student and maintained in accordance with NJAC 6A: 14. This release expires when all reports have been completed by the NJSCST.

Evaluations will be conducted in the following disciplines: (Check appropriate boxes.)

- ☐ Learning Evaluation
- ☐ Psychological Evaluation
- ☐ Speech and Language Evaluation

CERTIFICATION OF PARENTAL NOTIFICATION

I certify that the parents of the above named student are aware that the Specialized Child Study Team will be evaluating their son/daughter. Any permission to evaluate, or notification of the evaluations, required under New Jersey Administrative code are acknowledged to be the responsibility of, and will be completed by the School District.

_____
District Representative

_____
Position

_____
Date

(Revised 3/13)

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Regarding (student's name): _____ DOB: _____

Release of Information

Permission is granted by _____ (Parent/Guardian) to release to the NJ Specialized Child Study Team all information, reports, evaluations, summaries, etc., regarding the above named student. Consultations with parents and/or professional school personnel may also be conducted to obtain their impression of the student. All information will be used in professional confidence, in the interest of the student and maintained in accordance with NJAC 6A: 14. This release expires when all reports have been completed by the NJSCST.

_____

Parent's Signature

_____

Date

(Revised 11/12)