

**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:** June 13, 2012

Please place the following on the board agenda.

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 Full Evaluations Package at the rate of \$1750, Partial Evaluation Package at the rate of \$1350, Individual Evaluations at the rate of \$400 per evaluation for the 2012-2013 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)

**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**

Following the processing of your application, the SCST 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 SCST 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**

**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)

**REQUEST FOR SERVICE**

**PLEASE COMPLETE/SIGN ALL AREAS BELOW**  
Check Requested Services

<p><b>(currently unavailable)</b></p> <p><input type="checkbox"/> <b>FULL EVALUATION PACKAGE \$1750</b> Speech/Language Psychological Educational Social History: (Available on a limited basis-call to discuss) Staffing***</p>		<p><b>District Information:</b></p> <p>▶ _____ <b>Name of District</b></p>	
<p><input type="checkbox"/> <b>PARTIAL EVALUATION PACKAGE \$1350</b> Speech/Language Psychological Educational Staffing***</p>		<p>▶ _____ <b>Phone Number</b></p> <p>▶ _____ <b>Address</b></p>	
<p><input type="checkbox"/> <b>INDIVIDUAL EVALUATIONS</b></p> <p><input type="checkbox"/> Speech/Language \$400 <input type="checkbox"/> Educational \$400 <input type="checkbox"/> Psychological \$400</p> <p>Total Individual Evaluation Fee: _____</p> <p>NOTE: Staffing with SCST staff representatives is <b>NOT</b> included with an individual evaluation.</p> <p>***With a Full or Partial Package, upon request, and pending mutual scheduling availability, SCST representatives will attend your staffing to present their findings.</p> <p>NOTE: If the SCST 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 SCST. 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 SCST.</p>		<p>▶ _____ <b>City</b></p> <p>▶ _____ <b>State</b> <b>Zip</b></p> <p>▶ _____ <b>County</b></p> <p>▶ _____ <b>Name of Student</b></p> <p style="text-align: center;"><b>SIGN HERE</b> ▼</p>	
<p style="text-align: center;"><b>SCST USE ONLY</b></p> <p>Student's Name: _____</p> <p>Supervisor SCST _____ Date _____ Student Case# _____</p> <p>(revised 10/14/09)</p>		<p>Signature of District Representative</p> <p>▶ _____</p> <p><b>Name of District Representative</b> <b>Date</b> (please print)</p> <p>▶ _____ <b>Title of Person Authorizing Contract</b></p>	

**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 \_\_\_\_\_

Has a Consultant been Involved with this student?

Does the student have any visual problems?  
 No  Yes \_\_\_\_\_

No  Yes  Karen Noble  T. Sheehan  
 Wendy Eufemia

**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
- Self Contained Class
- Other: Please describe: \_\_\_\_\_
- Included with Interpreter
- Included without Interpreter
- Supported with itinerant teacher of the deaf

**LEA/OTHER INFORMATION**

Referring District: \_\_\_\_\_ County of Residence: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Reason for Referral:  Initial Classification  Triennial Evaluation  Other:

Describe any problems or areas of concern that you wish us to address during testing: \_\_\_\_\_

**Services being requested:** (Note: Individual Evaluations do not include staffing.)

- Full Evaluations: Speech/Language, Psychological, Educational, Staffing (Social - limited availability)
- Partial Evaluation: (Speech/Language, Psychological, Educational, Staffing)
- Individual(s):  Speech/Language  Psychological  Educational

**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)

Regarding (student's name): \_\_\_\_\_

**Release of Information**

Permission is granted by the \_\_\_\_\_ School District to release to the 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 SCST.

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

- Learning Evaluation
- Psychological Evaluation
- Speech and Language Evaluation
- Social History Evaluation (if available)

**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**

---

---

**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)

October 5, 2009

Dear Director/Business Manager: Union, New Jersey Public Schools

As per Subchapter 5, Providing Educational and Related Services in 6A:14-5.1. The Specialized Child Study Team for the Deaf, based at the Marie H. Katzenbach School for the Deaf in Trenton, NJ are employees of the Department of Education, State of NJ, and meet all requirements to perform independent child study team evaluations. As such, the 'Consultant Contract' that you have submitted for signature does not apply.

Sincerely,

Susan L. Preston  
Assistant to the Superintendent  
Specialized Child Study Team

ST-4 (2-00, R-12)

State of New Jersey  
DIVISION OF TAXATION

SALES TAX

FORM ST-4

ELIGIBLE NONREGISTERED  
PURCHASER: SEE INSTRUCTIONS \*\*

PURCHASER'S NEW JERSEY  
CERTIFICATE OF AUTHORITY NUMBER

227500501k

EXEMPT USE CERTIFICATE

To be completed by purchaser and given to and retained by seller.  
Please read and comply with the instructions given on both sides of this certificate.

TO Union School District Date 2/4/10  
(Name of Seller)  
2369 Morris Avenue Union NJ 07083  
Address City State Zip

The undersigned certifies that there is no requirement to pay the New Jersey Sales and/or Use Tax on the purchase or purchases covered by this Certificate because the tangible personal property or services purchased will be used for an exempt purpose under the Sales & Use Tax Act.

The tangible personal property or services will be used for the following exempt purpose:

GOVERNMENTAL AGENCY

The exemption on the sale of the tangible personal property or services to be used for the above described exempt purpose is provided in subsection N.J.S.A. 54:32B- 1 (See reverse side for listing of principal exempt uses of tangible personal property or services and fill in the block with proper subsection citation).

I, the undersigned purchaser, have read and complied with the instructions and rules promulgated pursuant to the New Jersey Sales and Use Tax Act with respect to the use of the Exempt Use Certificate, and it is my belief that the seller named herein is not required to collect and sales or use tax on the transaction or transactions covered by this Certificate. The undersigned purchaser hereby swears under the penalties for perjury and false swearing that all of the information shown in this Certificate is true.

MARIE H. KATZENBACH SCHOOL F/T DEAF

NAME OF PURCHASER PU BOX 535 (as registered with the New Jersey Division of Taxation)  
TRENTON, NJ 08625-0535

(Address of Purchaser)

By [Signature] AAT (Title)  
(Signature of owner, partner, officer of corporation, etc.)

**W-9**  
 (Rev. November 2005)  
 Department of the Treasury  
 Internal Revenue Service

**Request for Taxpayer  
 Identification Number and Certification**

Give form to the requester. Do not send to the IRS.

Print or type  
See Specific Instructions on page 2.

Name (as shown on your income tax return)  
**STATE OF NEW JERSEY - DEPT. OF EDUCATION**

Business name, if different from above  
**MARIE H. KATZENBACH SCHOOL FOR THE DEAF**

Check appropriate box:  Individual/Sole proprietor  Corporation  Partnership  Other **GOV'T AGENCY**  Exempt from backup withholding

Address (number, street, and apt. or suite no.)  
**320 SULLIVAN WAY PO BOX 535**

City, state, and ZIP code  
**TRENTON, NJ 08625-0535**

List account number(s) here (optional)

Requester's name and address (optional)  
**Cinnaminson Board Of Education  
 2195 Riverton Road, PO Box 224  
 Cinnaminson, NJ 08077**

**Part I Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number

--	--	--	--	--	--	--	--	--	--

Employer identification number

2	1	6	0	0	0	9	2	8
---	---	---	---	---	---	---	---	---

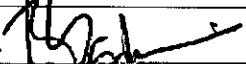
Note: If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

**Part II Certification**

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. person (including a U.S. resident alien).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here  Signature of U.S. person  Date **9/5/07**

**Purpose of Form**

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**U.S. person.** Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued).
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States.
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is the partner.

Post-it® Fax Note 7671 Date **11-2-09** # of pages **1**

To <b>Cathy Gilmartha</b>	From <b>A Baskin</b>
Co./Dept. <b>CST</b>	Co. <b>Katzenbach</b>
Phone #	Phone # <b>609.530.3104</b>
Fax # <b>908.851.6881</b>	Fax #



**New Jersey Specialized Child Study Team**  
 Evaluation Services for Students who are Deaf or Hard of Hearing  
 PO Box 535, Trenton, NJ 08625-0535  
 609-530-3145 (V/TTY) 609-530-3141 (FAX)

**, Fax Transmittal**

Name: Kathy Gilmartin

Fax #: 9080 851 6881  
~~9080 851 1462~~

- From:  Karen Noble       Lorraine Ascitutto       Kelly Maxwell  
 Barbara Battenhausen       Brett Bersano       Wendy Eufemia  
 Melissa Phillips

Date: 2/4/10      Total # of pages (including cover): 2

*Special Services*  
*Tax Ex. Letter*

---

---

---

---

---

---

---

---

---

---

(Revised 9/08)