SOUTH BERGEN JOINTURE COMMISSION

REQUEST FOR IN-HOME ABA PROGRAMMING

South Bergen Jointure Commission
Board of Education
696 Route 46 West
Teterboro, NJ 07608

Date of Request: _____

School District: _____

District Contact Person: _____ Phone # _____

Child's Name: _____ Grade: _____

Parent/Guardian Name: _____ Phone # _____

Address: _____

Check Services Requesting

☐ Parent Training (select one) _____ hours per WEEK

_____ hours per MONTH

_____ total number of hours requested

☐ In-Home ABA Therapy Program _____ visits per week x 60 minutes.

This service will be provided during:

☐ Regularly scheduled school days ONLY

☐ Uninterrupted (regular school days AND over school holidays)

☐ During ESY

☐ During August

Requested Start Date: _____ (two week lead time usually needed)

_____
Signature of Board Secretary or Designee

SBJC OFFICE USE ONLY

Coordinator: _____

ABA Therapists: _____

Start Date: _____