

824 10th Avenue; PO Box 129

Nebraska City, NE 68410

(402) 873-5513

[www.ncecbvi.org](http://www.ncecbvi.org)

­­­­­­­­­­­­­­­­­­**REQUEST FOR SERVICES**

**Outreach Department**

Please indicate the specific request(s) below. Once this form is received, you will be contacted about additional details which will further assist NCECBVI with the service request.

Return this form to the Outreach department by email: kjuilfs@esu4.net or by U.S.P.S.:

 NCECBVI, Attention: Kelly Juilfs, 824 10th Avenue, P.O. Box 129, Nebraska City, NE 68410-0129

**Student Name: School District/ESU:**

**Service(s) requested:**

 **Assessment/Evaluation\***

Psychological

 Functional Vision

 Learning Media

 ECC

 Orientation and Mobility

 Assistive Technology

 **Consultation\***

 **Professional Development**

 **Other (explain):**

**\*Attach the following documents (most current) for NCECBVI staff to review prior to serving your student.**

**REQUIRED: REQUESTED:**

MDT Functional Vision Assessment

 IEP Orientation and Mobility Evaluation

 Eye Doctor Report Psychological Report

 Learning Media Assessment

 ECC Assessment

 Low Vision Clinic Report

 Other Pertinent Medical Information

 Other Pertinent Educational Information

**Please list the specific outcomes you would like to see as a result of your request:**

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**Student Name:**

**Date of Birth:**

**Age:**

**Gender:** Female Male

**Grade:**

**School Building and School Address (Street/PO Box, City, Zip):**

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

**Name of Special Education Director or Student Services Director:**

**Office Phone:**

**Cell Phone:**

**Email:**

**Name of Teacher of the Visually Impaired:**

*The TVI will automatically be contacted about the request, unless otherwise specified.*

**Office Phone:**

**Cell Phone:**

**Email:**

**Name of Person to Receive Invoice:**

**Office Phone:**

**Email:**

**Billing Address (Street/PO Box, City, Zip):**

*Financial Agreement: The undersigned person, as a representative of the school district, authorizes services and agrees the school district is financially responsible for all charges incurred for services rendered by the Nebraska Center for the Education of Children who are Blind or Visually Impaired in accordance with the rates approved by the Nebraska Department of Education for the current school year. It is understood that all costs are considered allowable for special education reimbursement purposes.*

**Signature:Date:**

*(This is the person who authorizes the service request and billing.)*

**Complete this page *ONLY* if requesting an assessment, evaluation, or consultation.**

**­­­­­­­­­­­­­­­­­**

**PARENTAL CONSENT (Please complete if you agree):**

I have received a copy of the notice of this proposed evaluation and/or service, understand the content

 of this notice and **give consent** for the evaluation and services specified in this notice. I understand this

 consent is voluntary and may be revoked at any time.

 I **give consent** for photographs and videos to be taken of my child during services performed by

 NCECBVI to facilitate appropriate educational assessments, consultation, services, and program

 planning.

 **Parent/Guardian Signature:**

 **Date:**

*Parents of children with a disability have protection under the procedural safeguards of the Individuals with Disabilities Education Act (IDEA). A copy of these “Parental Rights in Special Education” can be obtained from the following website:* [*www.education.ne.gov*](http://www.education.ne.gov) *. You should read this information carefully and if you have any questions regarding your rights, you may contact Dr. Tanya Armstrong, NCECBVI Superintendent at 402-873-5513. You may contact any of the following resources to help you understand the federal and state laws for educating children with disabilities and parental rights granted by those laws. An explanation of your rights will be provided at no cost by any of the Nebraska Department of Education Regional Offices: Lincoln (402-471-2471), Omaha (402-595-2177), Educational Service Unit 4 (402-274-4354).*

**PERMISSION FOR RELEASE OF CONFIDENTIAL INFORMATION**

**Please complete if you agree:**

**I (parent/guardian name):**

**Parent/guardian of (student's name here):**

**Give my permission to release the following information concerning this child:**

 **Psychological Information**

 **Educational Information**

 **Medical Information**

 **Other:**

**to the Nebraska Center for the Education of Children who are Blind or Visually Impaired.**

 **Parent/Guardian Signature:**

 **Date:**

**Please complete this page if you give permission to be added to our email/mail databases.**

**PARENT CONTACT INFORMATION**

**Parent/Guardian Name(s):**

**Mailing Address (Street/PO Box)**

**City:**

**State:**

**Zip:**

**Preferred email address:**

**Preferred phone (include area code):**

**PARENT PERMISSION**

I give permission for my contact information to be added to the **mailing database** and understand I

 may receive information from NCECBVI periodically in the U.S. mail.

 I give permission for my contact information to be added to the **email database(s)** and understand I

 may receive information electronically from NCECBVI periodically.

 **Parent/Guardian Signature:**

 **Date:**

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