
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 Director by email: thilligoss@esu4.net, or by U.S. mail:
NCECBVI, Attention: Dr. Tanya Hilligoss, 824 10th Avenue, P.O. Box 129, Nebraska City, NE, 68410.

School District/ESU:

Service(s) requested:

Psychological Evaluation Intellectual, Academic, Social/Emotional/Behavioral, Developmental
Please attach the following: *Current MDT, IEP, Most Recent Psychological Report, Most Recent Eye
Doctor Report(s), Other Pertinent Medical/Health Information*

Mentoring for TVI

Professional Development

Transition Consultation
Please attach the following: Current IEP

Direct Service--ESU 4 school districts only

Other (explain):

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

Name of Person Requesting Services:

This is the person we will contact for additional information.

Position/Title:

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:

This is the person who authorizes the service request and billing.

Position/Title:

Office Phone:

Email:

Billing Address (Street/P.O. Box, City, Zip):

Signature:

Date:

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.

Complete this page
ONLY if requesting Psychological Evaluation, Transition Consultation, or Direct Service

Student Name:

Date of Birth:

Age:

Gender:

Grade:

School Building:

Include the appropriate grade level (elementary, middle school, high school, transition program, or other)

School Address (Street/P.O. Box, City, Zip):

School Principal Name:

School Principal Email:

School Principal Phone Number:

Administrator for Special Education Name:

Administrator for Special Education Email:

Administrator for Special Education Phone Number:

Following an evaluation or consultation, any reports will be emailed to the person making the request for this service, teacher of the visually impaired, school principal, and administrator for special education. If there are additional staff members who should receive a copy of any reports, please indicate below:

Name:

Position/Title:

Email:

Name:

Position/Title:

Email:

Complete this page
ONLY if requesting Psychological Evaluation, Transition Consultation, or Direct Service

PARENTAL CONSENT

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.

Signature of Parent/Guardian:

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. You should read this information carefully and if you have any questions regarding your rights, you may contact Sally Schreiner, NCECBVI Campus Administrator, at 402-873-5513 or 800-826-4355. 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

I, _____ Parent/Guardian of _____,
give my permission to release the following information concerning this child:

Psychological Information

Educational Information

Medical Information

Other:

Signature of Parent/Guardian:

Date: