AGREEMENT FOR NONPUBLIC, NONSECTARIAN SCHOOL/AGENCY SERVICES
(Education Code Sections 56365 et seq.)

This agreement is effective on 5-29-14 or the date student begins attending a nonpublic school or receiving services from a nonpublic agency, if after the date identified, and terminates at 5:00 P.M. on June 30, 2015, unless sooner terminated as provided in the Master Contract and by applicable law.

Local Education Agency(LEA)	San Leandro Unified School District			**Nonpublic School/Agency**	Center of Early Intervention on Deafness (CEID)		
Address	14735 Juniper Street			**Address**	1035 Grayson Street		
City, State Zip	San Leandro, CA 94579			**City, State, Zip**	Berkeley, CA 94710		
LEA Case Manager	Kimberly Kolbe			**Phone**	510-848-4800	**Fax**	510-848-4801
				e-Mail			
Student Last Name		**Student First Name**		**Program Contact Name**	Jill Stewart		
				Phone	510-848-4800 x 304	**Fax**	510-848-4801
D.O.B.	1/19/09	**I.D. #**		**e-Mail**	jstewart@ceid.org		
Grade		**Level**	**Sex** (X) M ( ) F	**Education Schedule – Regular School Year**			
Parent/ Guardian Last Name		**Parent/ Guardian First Name**		**Number of Days**		**Number of Weeks**	
				Education Schedule – Extended School Year			
				Number of Days	30	**Number of Weeks**	6
Address				**Contract Begins**	5-30-14	**Ends**	7-11-14
City, State, Zip	San Leandro, CA 94577			**Master Contract Approved by the Governing Board on**			
Home Phone		**Business**					

DESIGNATED INSTRUCTION AND SERVICES / RELATED SERVICES:

SERVICES	**PROVIDER**				**Cost and Duration of Session**	**Number of Sessions per wk/mo/yr**	**Maximum Number of Sessions**		**Estimated Maximum Total Cost for Contracted Period**
	LEA	**NPS**	**NPA**	**OTHER** Specify			**Reg School Year**	**ESY**	
A. BASIC EDUCATION									
B. RELATED SERVICES									
1. Transportation a. Paid to NPS/A b. Reimburse parent									
2. Counseling a. Group b. Individual c. Family									
3. Adapted P.E. a. Group of _____ b. Individual									
4. Speech/Language a. Group of _____ b. Individual c. Consultation									
5. SCIA a. Individual b. Group of ____									

STUDENT NAME: _____ DATE OF IEP: _____

B. RELATED SERVICES (cont'd)	PROVIDER				Cost and Duration of Session	Number of Sessions per wk/mo/yr	Maximum Number of Sessions		Estimated Maximum Total Cost for Contracted Period
	LEA	NPS	NPA	OTHER Specify			Reg School Year	ESY	
6. Intensive Academic Instruction									
7. Occupational Therapy a. Group of _____ b. Individual c. Consultation									
8. Physical Therapy a. Individual b. Consultation									
9. Behavior Intervention (BI) a. Consultation b. Direct (BII) c. Supervision (BID) d. Assessment		X			a. Consultation @$110.00 -per hour	1.5-per-week		6	$990.00
10. Nursing									
11. Mental Health									
12. Room/Board									
13. Other		X			ABA Aide @$37.00-per-hour	3-hours-per-day		30	$3,330.00
						TOTAL COST			**$4,320.00**

ESTIMATED MAXIMUM RELATED SERVICES COST $_____

SPECIALIZED EQUIPMENT/SUPPLIES _____ $ _____

TOTAL ESTIMATED MAXIMUM BASIC EDUCATION/ RELATED SERVICES COSTS/SPECIALIZED EQUIPMENT/SUPPLIES **$ 4,320.00**

4. Other Provisions/Attachments:

_____

_____

5. Progress Reporting Requirements: _____ Quarterly ___ Monthly ___ Other (Specify) _____

MASTER CONTRACT APPROVED BY THE GOVERNING BOARD ON

_____

The parties hereto have executed this Individual Services Agreement by and through their duly authorized agents or representatives as set forth below.

-CONTRACTOR-	-DISTRICT-
Center of Early Intervention on Deafness (CEID) (Name of Nonpublic School/Agency)	_____ (Name of School District)
_____ (Signature) (Date)	_____ (Signature) (Date)
Jill Stewart, Program Director (Name and Title)	_____ (Name of Superintendent or Authorized Designee)