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

This agreement is effective on October 19, 2015 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 May 30, 2016, 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**	**The Speech Pathology Group**		
Address	835 E. 14th Street			**Address**	**2021 Ygnacio Valley Road, C103**		
City, State Zip	San Leandro, CA 94577			**City, State, Zip**	**Walnut Creek, CA 94598**		
				e-Mail	**susan@speechpath.com**		
Student Last Name		**Student First Name**		**Program Contact Name**	**Jenny Ogar**		
				Phone	**(925) 945-1474 x131**	**Fax**	**(925) 945-1768**
D.O.B.	05/25/1999	**I.D. #**		**e-Mail**	**jenny@speechpath.com**		
Grade	**11**	**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		**Number of Weeks**	
Address				**Contract Begins**	**10/19/2015**	**Ends**	**5/30/2016**
City, State, Zip	**San Leandro, CA 94577**			**Master Contract Approved by the Governing Board on**	**08/28/2015**		
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 d. Assessment IEE			X	d. $126.00 per hr.	18-22 hours, including travel time and IEP attendance.				$2,772.00
5. SCIA a. Individual b. Group of ____									

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 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									
10. Nursing									
11. Mental Health									
12. Room/Board									
13. Other									
						TOTAL COST			$2,772.00

ESTIMATED MAXIMUM RELATED SERVICES COST $2,772.00

SPECIALIZED EQUIPMENT/SUPPLIES _____ $ _____

TOTAL ESTIMATED MAXIMUM BASIC EDUCATION/ RELATED SERVICES COSTS/SPECIALIZED EQUIPMENT/SUPPLIES $ _____

4. Other Provisions/Attachments:

_____

_____

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

MASTER CONTRACT APPROVED BY THE GOVERNING BOARD ON August 28, 2015

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

-CONTRACTOR-

The Speech Pathology Group, Inc.
(Name of Nonpublic School/Agency)

(Signature) 10/20/15 (Date)

Susan Stark, M.S., CCC-SLP, President
(Name and Title)

-DISTRICT-

_____
(Name of School District)

_____
(Signature) (Date)

_____
(Name of Superintendent or Authorized Designee)