SCHOOL YEAR: ________________

BLOCK GRANT FUNDS REIMBURSEMENT CLAIM FORM
L.E.A.S.E. I.D.E.A. GRANT #4620

DIAGNOSTIC

(Note: DO NOT attach documentation and receipts--maintain them at your district office.)

____ ____________

Name of Student *Birthdate*

______________________________ ______________________________

Resident School District *Attending School District*

*If claim is for Psychological or Speech and Language, explain why the evaluation could not have been done by a local district professional:*____

____

Type of Evaluation	Date of Eval.	Voucher/Check #	Actual Cost
Occupational Therapy			$ -
Physical Therapy			$ -
Neurological			$ -
Psychiatric			$ -
Neuro/Psychological			$ -
Psychological			$ -
Speech and Language			$ -
Assistive Technology			$ -
Other ____________			$ -

TOTAL THIS CLAIM (Actual Cost) **$ -**

TOTAL TO BE PAID THIS CLAIM AT 50% REIMBURSEMENT **$ -**

A copy of the Student Evaluation must accompany this form.

I certify that the services/items listed above were purchased and payments have been disbursed by this school district and that appropriate documentation/receipts are on file in this district office.

____

Name/Title of Person Completing This Form

____

Superintendent's Signature

__________________________ ____________

District *Date*

FOR L.E.A.S.E. USE ONLY

Approved *Date*

$

Amount To Be Paid

1-4120-300-0-3