

SBAP Direct Services Cost Worksheet for the 2009-2010 School Year

See reverse for instructions

LEA Name: ¹ _____

Service Specialty	Salaries ²	Benefits ³	Student Service Hours ⁴	Contracted Service Costs ⁵	Contracted Service Hours ⁶
Occupational Therapy	\$	\$		\$	
Audiology	\$	\$		\$	
Speech	\$	\$		\$	
Vision	\$	\$		\$	
Psychology	\$	\$		\$	
Psychiatry	\$	\$		\$	
Nursing – Registered Nurse	\$	\$		\$	
Physician	\$	\$		\$	
Social Work	\$	\$		\$	
Personal Care Assistant	\$	\$		\$	
Physical Therapy	\$	\$		\$	
Orientation and Mobility	\$	\$		\$	
Teacher of Hearing Impaired	\$	\$		\$	
Nursing – Practical Nurse	\$	\$		\$	
	\$	\$		\$	

Certification and Approval Section ⁸

Contact Information Section ⁷

I hereby certify that, to the best of my knowledge, the above data is true, correct, and prepared from the books and records of the LEA in accordance with applicable instructions.

Prepared By: _____

Title: _____

Date Prepared: _____

Phone: _____

Fax: _____

Signature: _____

Superintendent or Designee

Title: _____

Date: _____

Please attach the *Partially Federally Funded Staff Form*, if applicable, to this worksheet and submit both to Leader Services via fax: (570) 455-4526 or mail: P.O. Box O, Hazleton, PA 18201-0058.