

**NEW YORK STATE EDUCATION DEPARTMENT
STAC AND SPECIAL AIDS UNIT
REQUEST FOR REIMBURSEMENT FOR
Partial 1:1 AIDE, 1:1 NURSE, 1:1 INTERPRETER**

****FOR PRESCHOOL USE ONLY****

STAC ID# _____ (if known)

Student Name: _____ Date of Birth: _____

Preschool Provider Name: _____

Preschool Program Type/Name: _____

Type of 1:1: Partial 1:1 Aide _____ 1:1 Nurse RN _____ 1:1 Nurse LPN _____ 1:1 Interpreter _____
(check one)

➤ Is this 1:1 Aide/Nurse/Interpreter Shared? NO _____ YES _____

If YES, Number of Students Sharing the 1:1: _____

1:1 AIDE/NURSE/INTERPRETER--FOR PRESCHOOL EDUCATION:

Start Date of 1:1 Aide/Nurse/Interpreter: ____/____/____ Projected End Date: ____/____/____

Hours Per Day Program Runs: _____

Hours Per Day Student in Program: _____ Days Per Week Student in Prog: _____

1:1 Aide/Nurse/Interpreter Hrs/Day Requested: _____ 1:1 Days/Week Requested: _____

CPSE District of Residence/NYC District of Service Assurance

I have reviewed the above named student's records and assure that the student's Individualized Education Plan (IEP) specifically requires that a 1:1 Aide/Nurse/Interpreter be provided for the period indicated.

Date CPSE Superintendent of Schools/NYC- Superintendent of Clinical Services

Name of CPSE School District/NYC-District of Service

School District Contact Person: _____ Phone#: () _____

Fax #: () _____ E-mail Address: _____

PRESCHOOL REQUESTS: Submit this form and a signed STAC-1 form to the authorized municipality for signature. The municipality should then forward the 1:1 Aide/Nurse/Interpreter form to the STAC Unit.

NY STATE EDUCATION DEPARTMENT
STAC & SPECIAL AIDS UNIT
89 Washington Avenue - Room 514 EB
Albany, NY 12234
TEL: (518) 474-7116
FAX: (518) 402-5047

NEW YORK STATE EDUCATION DEPARTMENT
STAC & SPECIAL AIDS UNIT

**GUIDE FOR COMPLETING PART-TIME 1:1 AIDE
AND 1:1 RN, 1:1 LPN, 1:1 INTERPRETER REQUEST FORM**

- STAC ID#:** Enter the 6-digit student STAC ID#, if known.
- Student Name:** Enter the student's full name. *(Required)*
- Date of Birth:** Enter the student's date of birth. *(Required)*
- Preschool Provider:** Enter the name of the preschool service provider. *(Required)*
(For BOCES, indicate which BOCES.)
- Program Name:** Enter the name of the program the student attends. Please be specific.
Examples: Special Class, Integrated Setting
- Type of 1:1:** Indicate with a checkmark which type of 1:1 is being requested. *(Required)*
- Shared 1:1:** Indicate No or Yes with a checkmark. *(Required)* If yes, indicate the number of students sharing the 1:1.
- Start/End Date of 1:1:** Enter the date the 1:1 is expected to begin and end service. *(For Online Users, please amend the start and/or end date Online if different from the original date/s entered on the request).*
(Required)
- Hours Program Runs:** Enter the number of hours the program runs per day. *(Required)*
- Hrs/ Day - Days/Week**
- Student Attends:** Enter the number of hours per day and days per week the student attends the program. *(Required)*
- 1:1 Hours Per Day/
Days Per Week:** Enter the number of hours per day and days per week the student requires 1:1 services. *(Required)*
- Date & Signature:** The CPSE district superintendent must sign and date the Request form. *(Required)*
- Name of CPSE/
NYC District of Service:** Enter the CPSE District Name/NYC District of Service. *(Required)*
- School District
Contact Person/
Phone/Fax Number:** This section should be completed as a reference source should questions arise.