

NEW YORK STATE EDUCATION DEPARTMENT
STAC AND MEDICAID UNIT

**SCHOOL-AGE REQUEST FOR REIMBURSEMENT FOR
1:1 EDUCATION AIDES (other than full or half-time) and,
ALL 1:1 MAINTENANCE AIDES, RNs, LPNs, and INTERPRETERS f/t DEAF**

STAC ID# : _____ (if known)

Student Name: _____

Date of Birth: _____

Education Provider: _____

School Code: _____

Program Name: _____

Program Code: _____

- Type: Part-Time Aide _____ RN _____ LPN _____ Interpreter f/t Deaf _____
- Is this 1:1 Aide/Nurse/Interpreter Shared? No _____ Yes _____ No. of Students Sharing the 1:1 _____
- Component: Education Only _____ Maintenance Only _____ Education & Maintenance _____

1:1 FOR EDUCATION:

Requested Start Date of 1:1: _____/_____/_____ Projected End Date of 1:1: _____/_____/_____

Hours Per Day Program Runs: _____ Hours Per Day Student Attends _____ Days Per Week Student Attends _____

1:1 Hours Per Day Requested: _____ 1:1 Days Per Week Requested: _____

District of Residence/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 above.

CSE Responsible School District

CSE SED District Code

Date

Signature of Superintendent of Schools (NYC- Superintendent of Clinical Services)

1:1 FOR MAINTENANCE:

Report the following for the maintenance portion only of a CSE placed student in either an eligible in-state or out-of-state 853 residential facility, **excluding Children's Residential Project (CRP) Programs.**

Requested Start Date of 1:1: _____/_____/_____ Projected End Date of 1:1: _____/_____/_____

Hours of Service/Days of Service

School Days (M-F): _____ hrs./ 5 days

Non-School Days (S-S): _____ hrs./ 2 days

Salary and Fringe Benefits per hour: \$ _____

SED USE ONLY Approved: _____

Date: _____

Contact Person: _____ Phone #: () _____

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