

School Name: _____
 BEDS Code: _____

EXPENSE REQUEST AND CERTIFICATION

7/1/20-6/30/21

Expense Category: _____ **Amount:** _____
 Teacher Tuition or Test Expenses _____

CHIEF ADMINISTRATOR’S CERTIFICATION

I hereby certify that the requested budget amounts are necessary for the implementation of this project and that this agency is in compliance with applicable Federal and State laws and regulations, that these monies will be disbursed as supplemental compensation to teachers and that these monies will not be used to supplant teacher compensation received from other revenue sources. I further certify that when these expenditures become base year expenses they will be reported separately from other teacher compensation so as not to be reimbursed in subsequent years calculations of tuition rates.

_____ **Date** _____ **Signature**

Name and Title of Chief Administrative Officer

Phone #: _____ Fax #: _____ E-Mail Address: _____

Note: You must complete and return this document with the Chief Administrator’s original signature by November 13, 2020 to the attention of Sheila Costa at the New York State Education Department, STAC & Medicaid Unit, Room 514 EB West, 89 Washington Avenue, Albany, NY 12234. Replications will not be accepted.

STAC & Medicaid Unit APPROVAL:	FOR SED USE ONLY		
Approved By: Name: Date:	<u>Fiscal Year:</u>	<u>Amount Expended:</u>	<u>Final Payment:</u>
	<u>Voucher Number:</u>		<u>First Payment:</u>
	<u>Log</u>	<u>Approved</u>	<u>MIR</u>