

<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
STAC ID

<input type="text"/>
CIN NUMBER

<input type="checkbox"/> NEW STAC 200
<input type="checkbox"/> CHANGES TO A PREVIOUS STAC 200

1. Name of Student _____ (last) (first) (m)	2. Date of Birth ____/____/____
--	---

3. Gender of Student Male <input type="checkbox"/> Female <input type="checkbox"/>
--

4. Race Ethnic Category of Student (Explanation on reverse side) <input type="checkbox"/> Hispanic or Latino	Not of Hispanic Origin: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Two or more Races
---	--

5. Type of Placement (Check one) <input type="checkbox"/> Chapter 563 – Child Care Institutions <input type="checkbox"/> Chapter 947 – Residential Treatment Facilities
--

6. Public School District at Time of Admission to Care _____
--

7. Date of Admission to Care OR Date of Termination of Care/Change in Placement ____/____/____ ____/____/____

8. Public School District Certifying Disability _____

9. Name of Facility in Which Child Resides _____
--

10. DSS District or other Care Agency at Admission to Care _____
--

11. I CERTIFY THAT THIS CHILD HAS BEEN PLACED IN ACCORDANCE WITH THE INFORMATION INDICATED ABOVE:		
_____ (Signature of Person Completing this Form)	_____ (Title)	____/____/____ (Date)
_____ Address of Agency	(_____) (Area code)	- _____ (Telephone No.)

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<input type="checkbox"/> NEW STAC 200
<input type="checkbox"/> CHANGES TO A PREVIOUS STAC 200

1. Name of Student _____ (last) (first) (m)	2. Date of Birth ____/____/____
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3. Gender of Student Male <input type="checkbox"/> Female <input type="checkbox"/>
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1. Name of Student _____ (last) (first) (m)	2. Date of Birth ____/____/____
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3. Gender of Student Male <input type="checkbox"/> Female <input type="checkbox"/>
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_____ (Signature of Person Completing this Form)	_____ (Title)	____/____/____ (Date)
_____ Address of Agency	_____ (Area code)	_____ (Telephone No.)

Race/Ethnic Category of Student

All students must be reported as Hispanic/Latino or not Hispanic/Latino. In addition, all students must be reported with at least one race. Students, who are reported as Hispanic/Latino, regardless of their race, will be counted as Hispanic or Latino for accountability and other reporting purposes. Students who are reported as not Hispanic/Latino will be counted in the race category in which they are reported for accountability. Non-Hispanic students who are reported with more than one race category will be reported as Multiracial for accountability.

Completing TOP BOXES:

- **STAC ID:** Enter the student's 6-character STAC ID if known.
- **CIN NUMBER:** Enter the CIN number (client ID number) assigned to this student.
- **NEW STAC 200 or CHANGES TO PREVIOUS STAC 200:** Indicate with an "X" whether this is a new STAC 200 or if you are making corrections or changes to a previous STAC-200.

Completing (Items 1-11):

1. **Name of Student:** Enter student's last name, first name and middle initial.
2. **Date of Birth:** Enter student's date of birth expressed in digits (mo/day/year).
3. **Gender of Student:** Mark appropriate box for student's gender.
4. **Racial Ethnic Category of Student:** Circle one category of the student. Corresponding definitions are listed in the box at the top of this page.
5. **Type of Placement** - Check the appropriate box to indicate the Chapter Type Placement for this student.
 - **Chapter 563 – Child Care Institutions** – Any facility serving 13 or more children licensed by the Department of Social Services and operated by an authorized agency pursuant to Social Services Law [see 18 NYCRR §441.2(f)].
 - **Chapter 947 - Residential Treatment Facilities** – A community-based psychiatric inpatient facility designed to provide the level of supervision, medical oversight, and psychiatric treatment required by children and adolescents with severe emotional disabilities (see 13 NYCRR Part 589).
6. **Public School District at Time of Admission to Care:** Enter the name of the public school district in which the student's parent or legal guardian resided at the time the student entered the care of OMH/OCFS.
7. **Date of Admission to Care OR Date of Termination of Care/Change in Placement:** Enter the date the student was placed in the facility, terminated care, or changed placement expressed in digits (mo/day/year).
8. **Public School District Certifying Disability:** Enter the name of the public school district whose Committee on Special Education (CSE) has determined that this student has a disability as defined in Education Law §4401(1) and Commissioner's Regulations Part 200.1(zz).
9. **Name of Facility in Which Child Resides:** Enter the name of child care institution or residential treatment facility where the student currently resides.
10. **DSS District or other Care Agency at Admission to Care:** Enter the name of the local DSS district or other care agency in whose care the student has been placed.
11. **CERTIFICATION:** ALL FIVE COPIES must be completed and signed.

Send original to: NYS Education Department
STAC, Special Aids and Medicaid Unit
89 Washington Avenue, Room 514 EB
Albany, New York 12234
Phone: (518) 474-7116
Fax: (518) 402-5047

Copy Distribution

- Copy #1 – Placement Copy (SED)
- Copy #2 – Public School District Certifying Disability Copy
- Copy #3 – Public School District at Admission to Care Copy
- Copy #4 – Termination of Placement Copy
- Copy #5 – OMH Copy