NEW YORK STATE EDUCATION DEPARTMENT
STAC, SPECIAL AIDS AND MEDICAID UNIT

SCHOOL-AGE REQUEST FOR REIMBURSEMENT FOR FULL-TIME 1:1 AIDES, PART-TIME/SHARED 1:1 AIDES and 1:1 RN, 1:1 LPN, 1:1 INTERPRETERS f/t DEAF

FOR INSTRUCTIONS ON COMPLETING THIS FORM, PLEASE REFER TO THE 1:1 REQUEST GUIDE

STAC ID# : ______________________(if known)

Student Name: ________________________________ Date of Birth: ____________________________

Education Provider:____________________________ School Code: _____________________________

Program Name: ________________________________ Program Code: ____________________________

- Type: Full-Time Aide _____ 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 _____

<u>1:1 FOR EDUCATION ONLY</u>:

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:___________

<u>District of Residence/District of Service Assurance</u>
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)

<u>1:1 FOR MAINTENANCE ONLY:</u>

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.

Requested Start Date of 1:1:____/____/____ Projected End Date of 1:1 ____/____/___

<u>Hours of Service/Days of Service</u>

School Days (M-F):__________hrs./ __________days

Non-School Days (S-S):__________hrs./ __________days

Salary and Fringe Benefits per hour: $____________

*** SED USE ONLY Approved: Date:

Contact Person: ____ Phone #: ( )_____________
Fax #: ( ) _____________ E-mail Address:____________________________________