STAC ID

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
STAC & Special Aids Unit

STAC-5
07/02

Request for Commissioner's Approval of Reimbursement for the Cost of Evaluations

Please Print Clearly

1. NAME OF CHILD (Last) (First) (M.I.)

2. DATE OF BIRTH ____/____/____ Month Day Year

3. GENDER ☐ Male ☐ Female

4. SOCIAL SECURITY NUMBER

5. SIS CHILD ID NUMBER

6. Racial/Ethnic Category of Child (Definitions on the reverse side of this form)

☐ Amer. Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ Hispanic ☐ White

7. The child named above is:

☐ PD - Preschool Student With a Disability ☐ ND - Non-Disabled

8a. School District with CPSE Responsibility

b. County of Child's Current Location (where child resides)

c. County at time of Placement in Foster Care

9. Approved Evaluator

10. List the date each evaluation component was completed (use four digits to indicate month and year). For bilingual evaluations indicate on line provided.

EVALUATION COMPONENT		Month / Year	Check if Bilingual
Physical/Medical	PHY	____/____	_____
Social	SOC	____/____	_____
Psychological	PSY	____/____	_____
Audiological	AUD	____/____	_____
Education	EDU	____/____	_____
Neurological	NEU	____/____	_____
Neuropsychological	NPY	____/____	_____
Occupational Therapy	OCT	____/____	_____
Optometric (visual)	OPT	____/____	_____
Orthopedic	ORT	____/____	_____
Otolaryngology	OTO	____/____	_____
Physical Therapy	PHT	____/____	_____
Psychiatric	PYC	____/____	_____
Speech / Language	SPT	____/____	_____

11. Cost of translation/transmittal of evaluation documentation or summary report for monolingual evaluations only. $ _____

12. CERTIFICATION OF EVALUATION: I certify that the preschool child herein named received a multidisciplinary evaluation as indicated above and in accordance with Section 4410 of the Education Law and the Regulations of the Commissioner of Education.

Signature CPSE Chairperson_____ Date _____ CPSE Review Date (if different) _____

13. MUNICIPALITY SIGNATURE SECTION:

The municipality of _____ has received on ____/____/____ the STAC-5 Request for Commissioner's Approval of Reimbursement for the Cost of Evaluations for the above named child pursuant to Section 4410 of the Education Law.

Signature of Authorized Representative of the Municipality_____ Date_____

PLEASE PRINT THE NAME AND ADDRESS OF THE PERSON COMPLETING THIS FORM IN THE SPACE PROVIDED ON THE BACK OF THE ORIGINAL

Definitions of Racial/Ethnic Categories for Item 6 on reverse side of this form:

1. **American Indian or Alaskan Native** – A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.
2. **Asian or Pacific Islander** – A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands and Samoa.
3. **Black** – A person having origins in any of the black racial groups of Africa.
4. **Hispanic** – A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish Cultural or origin, regardless of race.
5. **White** – A person having origins in any of the original peoples or Europe, North Africa, or the Middle East.

INSTRUCTIONS TO THE PUBLIC SCHOOL DISTRICT WITH CPSE RESPONSIBILITY.

1. Complete items 1 through 8.
2. List the State Education Department Approved Evaluator in Item 9.
3. Provide evaluation dates for the components of the multidisciplinary evaluation in item 10. **If any evaluation component was conducted in a language other than English, indicate on the line provided to the right.**
4. Item 11 should be completed to identify the costs of translating the summary report, for monolingual evaluations.
5. The CPSE Chairperson must sign and date the STAC-5 in item 12.
6. Keep the "CPSE Copy" and forward copies to the county listed in Item 8b.

INSTRUCTIONS TO THE COUNTY OF CHILD'S CURRENT LOCATION.

1. Complete Item 13.
2. Keep one copy, forward a copy to the approved evaluator and the original to:

   NYS Education Department
   STAC and Special Aids Unit
   514 West Hall, Education Bldg.
   Albany, New York 12234

* Electronic filers – Do not send a paper copy to SED.

PERSON COMPLETING THIS FORM

NAME:_____ TITLE:_____

PHONE:_____