STAC-812 The University of the State of New York Rev. 09/2020
THE STATE EDUCATION DEPARTMENT

Request for Reimbursement for Student-Specific Nurses and Interpreters

For Preschool Use Only

STAC-ID | | | | | | |

Do NOT submit this form for:

- **Education Aides**
  (Enter aide percentage on EFRT service approval screen)

A completed and signed Preschool STAC-1 form should be submitted along with this form.
Scan and upload both completed forms to SED File Transfer Manager (FTM) "inbasket".
Email OMSSTAC@nysed.gov with the SED FTM location and filenames. Do NOT attach completed forms to emails.

STUDENT, COUNTY, AND SCHOOL DISTRICT INFORMATION	
Student Name:	Date of Birth (mm/dd/yy): _____
County of Residence Name:	
Name of School District with CPSE Responsibility:	School District SED Code:

AIDES/NURSES/INTERPRETERS DURING EDUCATION HOURS				
☐ **Aide**	Requested Start: _____ to Requested End: _____	Hours 1:1 Requested: ____ Hours / Day	Days 1:1 Requested: ___ Days / Week	Shared by multiple students: ☐ No ☐ Yes: ____ students
☐ **RN**	Requested Start: _____ to Requested End: _____	Hours 1:1 Requested: ____ Hours / Day	Days 1:1 Requested: ___ Days / Week	Shared by multiple students: ☐ No ☐ Yes: ____ students
☐ **LPN**	Requested Start: _____ to Requested End: _____	Hours 1:1 Requested: ____ Hours / Day	Days 1:1 Requested: ___ Days / Week	Shared by multiple students: ☐ No ☐ Yes: ____ students
☐ **Interpreter**	Requested Start: _____ to Requested End: _____	Hours 1:1 Requested: ____ Hours / Day	Days 1:1 Requested: ___ Days / Week	Shared by multiple students: ☐ No ☐ Yes: ____ students

PRESCHOOL EDUCATION PLACEMENT	
Education Provider Name:	Education Provider SED Code:
Program Name:	Program Code: -
Program Runs: _____ Hours/Day _____ Days/Week	Student Attends: _____ Hours/Day _____ Days/Week

CPSE DISTRICT OF RESIDENCE/NYC 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.

_____ _____
Signature: CPSE Superintendent of Schools/NYC Superintendent of Clinical Services Date

PERSON COMPLETING THIS FORM	
Name	Phone
Fax	Email