THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

OFFICE OF SPECIAL EDUCATION
SPECIAL EDUCATION QUALITY ASSURANCE
NONDISTRICT UNIT
89 Washington Avenue, Room 309 EB • Albany, NY 12234
Telephone (518) 473-1185
www.p12.nysed.gov/specialed

1 Park Place, 3rd Floor, Peekskill, NY 10566
Telephone (914) 940-2900

APPLICATION FOR TUITION ASSISTANCE PROGRAM FOR DEAF INFANTS

Infant's Name: _____ (Last) _____ (First) Sex: ☐ F ☐ M

Date of Birth: _____ (Month) _____ (Day) _____ (Year) Age in Months: _____

How long has this infant been a resident of New York State? _____

STATEMENT OF PARENT OR LEGAL GUARDIAN

I, the parent or legal guardian of the above-named infant, hereby apply for admission for my deaf infant to the deaf infant program at (fill in name of approved agency) _____ and for State assistance for the approved educational program. I hereby grant permission for the release to the State Education Department of necessary documents to support my infant's eligibility for entrance into the deaf infant program in public or private agencies approved by the Commissioner of Education and for continuation therein. I declare that I am not presently eligible for or receiving financial support for the requested educational service from any State or local government agency or through private insurance.

Name of Parent or Legal Guardian (please print): _____ (Last) _____ (First)

Signature: _____ Date _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

County: _____ Telephone Number: _____

Is this the child's primary handicapping condition? ☐ Yes ☐ No

If no, what is the child's primary handicapping condition? _____

List other evaluations that have been done: _____

SED USE ONLY

☐ Approved ☐ Denied

_____ Signature of Representative

_____ Date