Nassau County **APPENDIX A**

DEPARTMENT OF HEALTH

OFFICE OF CHILDREN WITH SPECIAL NEEDS

Preschool Special Education Program

60 Charles Lindbergh Blvd. Suite 100
Uniondale, New York 11553-3683

HOME LANGUAGE SURVEY

Child's Name: _____

Child's DOB: _____

1. What is your relationship to the child: Check one: c Mother c Father c Guardian

2. English is the only language my child is exposed to: c YES

   c NO

School District instructions:
If parent checks "NO" then fax form to evaluator along with consent and referral so a bilingual evaluation can be arranged.

3. What language did your child learn when he/she first began to talk? _____

4. What language(s) does your family speak in your home? _____

5. In what language(s) does the mother speak to her child? _____

6. In what language(s) does the father speak to his child? _____

7. In what language does the caretaker speak to your child? _____How often? _____

8. What language(s) does your child seem to respond to most readily?_____

9. In what language does your child speak to his/her brothers and sisters? _____

10. If born outside the continental United States, where was your child born? _____

11. How long has your child been exposed to English? _____

School District instructions:
If answer to # 11 is less than three months, suggest a three-month waiting period.

12. Did the child spend time in a: c Foster Home c Orphanage

_____ _____
Parent's signature Date

_____ _____
School official completing form Title

Nassau County
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
60 Charles Lindbergh Blvd. Suite 100
Uniondale, New York 11553-3683

HOME LANGUAGE SURVEY

Nombre del Niño(a): _____
Fecha de Nacimiento: _____

1. Cual es su parentesco con el/la niño/a? Marque 1: Madre Padre Guardián Legal
2. Su hijo(a) está expuesto únicamente al inglés? SÍ ☐ NO

Instrucciones para el distrito escolar:
Si los padres seleccionan "NO" mándeles por fax a los evaluadores este formulario con el consentimiento correspondiente y un formulario de referido para que se pueda hace una evaluación bilingüe.

3. Que idioma(s) aprendió su hijo(a) cuando primero comenzó a hablar? _____
4. Qué idioma(s) se habla(n) en su casa? _____
5. Qué idioma le habla la madre al niño(a)? _____
6. Qué idioma le habla el padre al niño(a)? _____
7. Qué idioma le habla la persona que cuida al niño(a)? _____Qué tan a menudo? _____
8. En qué idioma(s) se le hace más fácil responder a su hijo(a)? _____
9. Qué idioma(s) le habla su hijo(a) a sus hermanos y hermanas? _____
10. Si nació fuera de Estados Unidos (continental), dónde nació su hijo(a)? _____
11. Cuanto tiempo lleva su hijo(a) expuesto al inglés? _____

Instrucciones para el distrito escolar:
Si la respuesta a la pregunta 11 es menos de 3 meses, sugiera esperar 3 meses

12. Su hijo ha pasado tiempo en un: ☐ Hogar de Crianza (*Foster Care*) ☐ Orfanato

_____ _____
Firma de(l/la) Madre, Padre o Guardián Legal Date

_____ _____
Personal Escolar Completando este formulario Title

Nassau County
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
60 Charles Lindbergh Blvd. Suite 100
Uniondale, New York 11553-3683

SONDAJ SOU LANG AKEY

Non ak siyati Timoun lan: _____
Dat Timoun nan Fèt: _____

1. Ki relasyon ou a pitit la : Tyeke youn: ☐ Manman ☐ Papa ☐ Gadyen

2. Angle se lang la sèlman pitit mwen an ekspoze: ☐ WI
☐ NON

Enstriksyon Distri Lekòl la:
Si paran tyeke "NON" Lè sa a, fòm faks nan evalyatè ansanm ak konsantman ak rekòmandasyon pou yon evalyasyon de lang dwe ranje.

3. Ki lang pitit ou an te aprann lè li te fèk ap pale? _____

4. Ki lang yo pale nan kay la? _____

5. Ki lang manman an pale ak pitit li? _____

6. Ki lang papa a pale ak pitit li? _____

7. Ki lang gadyen an pale ak pitit ou a? _____Konbyen fwa? _____

8. Ki lang ou wè pitit ou an pi fasil reponn ou? _____

9. Ki lang pitit ou a pale avèk frè li e sè li ? _____

10. Si li pat fèt nan peyi Etazini,nan ki peyi pitit ou a te fèt? _____

11. Pou konbyen tan pitit ou a te ekspoze nan angle? _____

Enstriksyon Distri Lekòl la:
Si repons #11 la gen mwens pase twa mwa,nou sujere yon twa mwa datant.

12. Eske timoun nan pase tan nan yon : ☐ Fanmi Akèy ☐ Orfelina

_____ _____
Siyati paran Dat

_____ _____
Fòm ofisyèl lekòl la TitI

Nassau County
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
60 Charles Lindbergh Blvd. Suite 100
Uniondale, New York 11553-3683

家庭语言调查

小孩姓名: _____

小孩出生日期: _____

1. 您是以上小孩的: (请打勾) ☐ 母亲 ☐ 父亲 ☐ 监护人
2. 英语是不是你小孩唯一接触过的语言 ☐ 是的 – 您不需回答以下的问题
   ☐ 不是 – 请回答以下的问题

学区工作人员:
如果家长回答"不是"请传真此表格、评估同意书和评估推荐信给负责评估的单位以便安排双语评估。

3. 在你小孩刚学讲话的时候，他/她学的是什么语言? _____
4. 您的家庭成员在您家里都讲些什么语言? _____
5. 小孩的母亲对他/她讲什么语言? _____
6. 小孩的父亲对他/她讲什么语言? _____
7. 小孩的保姆或照顾小孩的人对他/她讲什么语言? _____
   有多频繁? _____
8. 您的小孩看起来最听得懂并会作出回应的语言是? _____
9. 您的小孩对他/她的兄弟姐妹讲什么语言? _____
10. 您的小孩在哪里出生(如果不是在美国出生)? _____
11. 您的小孩接触英语有多久? _____

学区工作人员:
如果对第 11 个问题的回答是少于三个月，请建议家长等到有三个月以后。

12. 您的小孩有没有曾经生活在: ☐ 寄养家庭 ☐ 孤儿院

_____ _____
家长签名 日期

_____ _____
学区工作人员 职务

EI 5231 11-15-10

Nassau County
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Early Intervention Program
Preschool Special Education Program
Physically Handicapped Children's Program
60 Charles Lindbergh Blvd., Suite 100
Uniondale, NY 11553-3683

SCHOOL DISTRICT REQUEST FOR EI PROGRESS REPORTS

School District: _____

Chairperson: _____

Mailing Address: _____

Town, Zip Code: _____

In order to assist transition planning please forward the following child's most recent Progress Reports to the above address.

Child's Name	Date of Birth
_____	____/____/____

If you have any questions please call:_____
(Name of Contact Person) **(Phone Number)**

APPENDIX C

STAC 202 - Designation of School District of Attendance for a Homeless Child

Link to fillable NYSED STAC 202 form with instructions:

STAC-202 Homeless Designation (nysed.gov)

APPENDIX D

NASSAU COUNTY
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Early Intervention Program
Preschool Special Education Program
Physically Handicapped Children's Program
60 Charles Lindbergh Blvd., Suite 100
Uniondale, NY 11553-3683

NOTIFICATION TO DEPARTMENT OF HEALTH EARLY INTERVENTION PROGRAM OF ELIGIBILITY DETERMINATION FOR TRANSITIONING EI CHILD AND ELIGIBILTY DATES

Child's Name: _____ DOB: _____

	MONTH	DAY	YEAR
CPSE Meeting Date:			
First eligible for Preschool Evaluation process :			
First eligible for Preschool (4410) Services:			
Date on which Preschool services are expected to begin:*			
Amended start date: (refax this form at the number below)			

*** If expected date changes it is the responsibility of the school district to notify the Nassau County Department of Health Early Intervention service coordinator.**

Select One Below:

The above-named child has been determined by the CPSE:

[ ] **Eligible** for CPSE services
or
[ ] **Not Eligible** for CPSE services

c Consent for release of current and future EI Progress Reports and/or EI Evaluations to school district CPSE.

_____ _____/_____/_____
Parent Signature Date

_____ _____/_____/_____
CPSE Chair/**School District** Date

IMMEDIATELY FOLLOWING THE INITIAL CPSE MEETING:

- FAX THIS FORM DIRECTLY TO THE NASSAU COUNTY DEPARTMENT OF HEALTH AT 516-227-8663 OR
- PRESENT THIS FORM TO THE NASSAU COUNTY EARLY INTERVENTION SERVICE COORDINATOR

APPENDIX E

Department of Health
Office of Children with Special Needs
Preschool Special Education Program
60 Charles Lindbergh Blvd. Suite 100
Uniondale, New York 11553-3683

Request for Translation and/or Bilingual Evaluation

Child's Name: _____ DOB: _____

Parent Name: _____ Phone: _____

Address: _____

Language: _____

School District Authorizing Evaluation: _____

Evaluation Agency: _____

1. _____ Participation of a translator for the evaluation process.

2. _____ Translation of Summary Report.

3. _____ Translation of Documentation of the Evaluation.

Parent/Guardian Signature: _____ Date: _____

Instructions:

- Evaluation Provider:

This completed form must be submitted to the school district CPSE Office with the Evaluation-Verification Detail Page.

- School District CPSE Office:

Submits this form with the STAC-5 and Evaluation Verification-Detail page to the NCDOH STAC Unit

1. The cost of administering a CPSE authorized bilingual evaluation and providing the translated Summary Report and Evaluation Documentation to the family is part of the NYSED approved bilingual evaluation rate. Place check mark in bilingual column on STAC-5.
2. Complete section 11 of the STAC-5 only if evaluation was authorized as monolingual and the Summary Report was translated into a language other than English. Obtain the Translation Cost from the Evaluation Verification-Detail Page. ***Do not*** place a check mark in the bilingual column on the STAC-5.
3. Complete section 11 of the STAC-5 only if evaluation was authorized as monolingual and the Evaluation Documentation was translated into a language other than English at the parent's request. Obtain the Translation Cost from the Evaluation Verification-Detail Page. ***Do not*** place a check mark in the bilingual column on the STAC-5.

NASSAU COUNTY DEPARTMENT OF HEALTH-PRESCHOOL SPECIAL EDUCATION PROGRAM

EVALUATION VERIFICATION & DETAIL PAGE FOR JULY 1, 20__, THROUGH JUNE 30, 20__

APPENDIX F

(THIS VERIFICATION - DETAIL PAGE **MUST** BE SUBMITTED **TO THE SCHOOL DISTRICT** & A COPY **MUST** BE ATTACHED TO THE **CLAIM VOUCHER**)

PROVIDER:

CHILD'S NAME:	**DATE OF BIRTH:**	**DISTRICT:**
PARENT NAME/ADDRESS:		**DATE:**

☐ INITIAL EVALUATION (for the child's first CPSE meeting)

An initial evaluation cannot exceed 6 evaluation components (consisting of a social history, psychological and up to four others) without the WRITTEN AUTHORIZATION of the CPSE.

☐ **RE-EVALUATION OR ADDITIONAL EVALUATION**

Requires CPSE written authorization

EVALUATION COMPONENT(S)	**DATE COMPLETED**	**NAME OF PROFESSIONAL PERFORMING EVALUATION**	**EVALUATION RATE** RATE	**EVALUATION RATE** TOTAL	**BILINGUAL EVALUATION RATE** RATE	**BILINGUAL EVALUATION RATE** TOTAL	**DOH APPROVED**
☐ **Physical/Medical**			**$214.00**		**$265.00**		
☐ **Social History**			**$168.00**		**$219.00**		
☐ **Psychological**			**$291.00**		**$377.00**		
☐ **Speech/Language**			**$194.00**		**$240.00**		
☐ **Physical Therapy**			**$194.00**		**$240.00**		
☐ **Occupational Therapy**			**$194.00**		**$240.00**		
☐ **Education**			**$194.00**		**$240.00**		
☐ **Audiological**			**$194.00**		**$240.00**		
☐ **Other (Please Specify Type) * Physician:**			**$214.00**		**$265.00**		
☐ **Other (Please Specify Type) ** Non-Physician:**			**$194.00**		**$240.00**		
		SUBTOTAL - CLAIM FOR EVALUATION COMPONENTS:				$	

TRANSLATION: (Copy of signed and dated parent request form **MUST** be attached.)	☐ **SUMMARY REPORT WAS TRANSLATED INTO** Specify Language:	**Cost:**	$
	☐ **EVALUATION DOCUMENTATION ALSO TRANSLATED AT PARENT REQUEST**	**Cost:**	$
	SUBTOTAL - CLAIM FOR TRANSLATION COSTS:		$
	TOTAL CLAIM: EVALUATION + TRANSLATION COSTS:		$

*(NEUROLOGICAL, NEUROPSYCHOLOGICAL, PSYCHIATRIC, OPTOMETRIC, ORTHOPEDIC, OTOLARYNGOLOGY)

* *(AUGMENTED COMMUNICATION, EVALAUTION BY A TEACHER OF THE DEAF, EVALAUTION BY A TEACHER OF THE BLIND/VISUALLY IMPAIRED)

Please refer to NYSED's http://www.oms.nysed.gov/stac/preschool/policy/eval3-4yr803.pdf pages 8 to 11 for more information regarding evaluation components.

Authorized Representative of the Evaluation Site

APPENDIX G

ACKNOWLEDGEMENT OF LRE BY CPSE

The Regulations of the Commissioner of Education, part 200.1(cc) define **Least Restrictive Environment** (LRE) as "the placement of students with disabilities in special classes, separate schools or other removal from the regular educational environment occurs *only when* (emphasis added) the nature or severity of the disability is such that *even with* (emphasis added) the use of supplementary aids and services, education cannot be satisfactorily achieved. The placement of an individual student with a disability in the least restrictive environment shall:

1. Provide the special education needed by the student;
2. Provide for education of the student to the maximum extent appropriate to the needs of the student with other students who do not have disabilities; and
3. Be as close as possible to the student's home"

Part 200.6(a)(1) reads "Students with disabilities shall be provided special education in the **least restrictive environment** . . . . To enable students with disabilities to be educated with nondisabled students to the maximum extent appropriate, specially designed instruction and supplementary services may be provided in the regular class including, as appropriate, providing related services . . . within the general education classroom." The Office of Special Education Programs has reiterated that the **least restrictive environment** requirements in section 612(a)(5) of IDEA are fully applicable to the placement of preschool children with disabilities. IDEA indicates a strong preference for educating students in regular classes with appropriate aids and supports and stresses children with disabilities must be educated with children who are not disabled to the maximum extent appropriate. Before a child with a disability can be placed outside the regular educational environment, the CPSE must consider whether supplementary aids and services could be provided that would enable the education of the child in the regular educational setting to be achieved satisfactorily. 34 CFR §300.114(a)(2). To that end, the expectation of NYSED and NCDOH is a preschooler with a disability should have the opportunity to be educated with typical peers, whenever possible, until such time as it is determined that education cannot be satisfactorily achieved in the general education setting even with supplementary services.

Instructions for CPSE chairperson: please sign the below attestation after each CPSE meeting where a self-contained class in a Centerbased program is recommended.

Child's name: _____ DOB: _____

I certify that this preschooler cannot be satisfactorily educated among his/her typical peers in a general education setting even with appropriate supplementary services provided. I further certify that this placement is as close as possible to the preschooler's home.

_____ _____

Chairperson's signature (stamp not acceptable) Date

APPENDIX H

NASSAU COUNTY PRESCHOOL SPECIAL EDUCATION PROGRAM
REGRESSION TOOL

Name of Student _____ DOB _____ Discipline _____ Frequency _____

Date Range of Missed Sessions _____to _____ # of Consecutive Sessions Missed ____Reason _____

Name of Provider/Agency/School _____

Skill Attainment Prior to Treatment Interruption					
Short Term IEP Objective(s) with measurable progress	Record Date and Data collected for each session to establish a Baseline				
	Session 1	Session 2	Session 3	Session 4	Session 5
#1	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
#2	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
#3	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __
#4	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __

(Baseline Data must be a <u>minimum</u> of 3 Session Dates)

Skill Attainment Post Treatment Interruption									
Short Term IEP Objectives	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	# of weeks to recoup learned skill to the level prior to interruption
#1									
#2									
#3									
#4									

RATIONALE FOR EXTENDED SCHOOL YEAR: Additional pertinent information; include or attach all charting, documentation, method and criteria used, and any other information to justify recommendation for Extended School Year.

_____

_____

_____

_____

Provider Signature: _____ License/Certificate _____Date:_____

Please remember, the purpose of Extended School Year services is to <u>prevent substantial regression</u> and maintain progress.

This form was created to assist providers in collecting regression data and submitting this data to the CPSE to support a recommendation for Extended School Year (ESY) as well as to assist school districts in assessing the need for an appropriate recommendation for ESY. The County strongly encourages this form to be used. Regression data may be included in the provider's quarterly and/or annual reports to provide the information to the CPSE.

First and most important, this form should **NEVER** be submitted if the provider is not recommending ESY!

If this form is completed, it does not equate to an automatic recommendation by the CPSE for ESY. As indicated in Part 200 Regulations of the Commissioner of Education, once the need to prevent substantial regression is established, the child "**may be considered for**" ESY **if** they fall within one of the five categories described in section 200.16(i)(3)(v).

REGRESSION TOOL INSTRUCTIONS

(Revised February 2021)

Skill Attainment Prior to Treatment Interruption:

1. Include the date range where no services were provided. An extended weekend in isolation is not a sufficient interval on its own without services with which to prove substantial regression.

2. Identify more than one short term objective, benchmark or skill in your area of expertise that the child has achieved or mastered. (If there aren't any then it is the provider's responsibility to contact the school district's CPSE chairperson to discuss the possibility of creating more realistic and achievable/attainable goals.)

3. Enter the date of data collection and data, consistent with criteria as per the IEP, under each session # where the baseline data was collected for each skill. The provider is not required to collect data on consecutive days.

Skill Attainment Post Treatment Interruption:

4. The skill identified should be targeted at least weekly. Report on the session most representative of the child's functioning.

5. Enter the data collected during the session deemed most representative of the present level of functioning during that week (ex. 4/5 trials, 50% success rate). This should be done for each objective. **Substantial regression cannot be indicated if the skill was not worked on.**

6. In the last column, enter the number of weeks the child took to recoup the skill to the level prior to interruption. (As per NYSED guidance, the typical period of review or reteaching ranges between 20 and 40 school days. As a guideline, a review period of eight weeks or more without recoupment of the skill would indicate substantial regression has occurred.)

7. Additional information to explain/justify recommendation of ESY can be included on the bottom of the page.

APPENDIX I

SAMPLE FORM
Written Notification Regarding Use of Public Benefits or Insurance to Pay for Certain Special Education and Related Services

This form has been adapted from the U.S. Department of Education's model Notification Form1 .

INTRODUCTION

You are receiving this written notification to give you information about your rights and protections under the federal Individuals with Disabilities Education Act (IDEA), so that you can make an informed decision about whether you should give your written consent to allow your school district/county to use your or your child's public benefits or insurance to pay for special education and related services that your school district is required to provide at no cost to you and your child under IDEA.

Funds from a public benefits or insurance program (for example, Medicaid funds) may be used by your school district (or, for preschool students, the county) to help pay for special education and related services, but only if you choose to provide your consent, as explained below.

Before your school district or county can ask you to provide consent to check with the New York State Department of Health whether your child has public benefits or insurance (e.g., Medicaid coverage and/or a Client Identification Number (CIN)), and to access these benefits or insurance for the first time, it must provide you with this notification of the rights and protections available to you under IDEA. This notification is intended to help you understand these rights and protections, including the type of consent your school district will ask you to provide. Whether or not you provide consent, your school district has a continuing responsibility to ensure that your child is provided all required special education and related services under IDEA at no charge to you or your child.

PARENTAL CONSENT
34 CFR §300.154(d)(2)(iv)(A)-(B) and 8 NYCRR §200.5(b)(8)(i)

Before your school district (or for preschool students, your county) can use your or your child's public benefits or insurance for the first time to pay for special education and related services under IDEA, it must obtain your signed and dated written consent. Your school district is only required to obtain your consent one time.

This consent requirement has two parts.

1. Consent to share records about your child: Your school district is required to obtain your written consent before disclosing (sharing) personally identifiable information about your child (such as your child's name, address, social security number, individualized education program (IEP), and evaluation results) from your child's education records. In asking for your consent, the school district will (1) identify the records (or information) about your child that will need to be shared (for example, about the services that may be provided to your child); (2) tell you the purpose of sharing the records (for example, billing for special education and related services); and (3) identify the agency to which your school district may disclose the information (for example, the Medicaid agency).

2. Consent to check with the New York State Department of Health whether your child has a CIN/public benefits or insurance (Medicaid) coverage, and bill your child's public benefits or insurance (Medicaid) program: Your consent must include a statement specifying that you understand and agree that your school district or county, for preschool, may use you or your child's public benefits or insurance (e.g., Medicaid) to pay for some of your child's special education services.

You have the right to withdraw your consent at any time. If you withdraw your consent, the school district must still provide all of your child's IEP special education and related services at no cost to you. To withdraw your consent, you will need to submit your request in writing to your child's school district.

NO COST PROVISIONS
34 CFR §300.154(d)(2)(i)-(iii) and 8 NYCRR §200.5(b)(8)(ii)(b)-(d)

The IDEA "no cost" protections regarding the use of public benefits or insurance are as follows:

1. Your school district may not require you to sign up for or enroll in a public benefits or insurance program in order for your child to receive a free appropriate public education.

2. Your school district may not require you to pay any out-of-pocket expenses, such as the payment of a deductible or co-pay amount for filing a claim for services that your school district is otherwise required to provide your child without charge.

3. Your school district may not use your or your child's public benefits or insurance if using those benefits or insurance would:

a. decrease your available lifetime coverage or any other insured benefit, such as a decrease in your plan's allowable number of physical therapy sessions available to your child or a decrease in your plan's allowable number of sessions for mental health services;
b. cause you to pay for services that would otherwise be covered by your public benefits or insurance program because your child also requires those services outside of the time your child is in school;
c. increase your premium or lead to the cancellation of your public benefits or insurance; or
d. cause you to risk the loss of your child's eligibility for home and community-based waivers that are based on your total health-related expenditures.

We hope this information is helpful to you in making an informed decision regarding whether to allow your school district or county, for the provision of preschool special education, to use your or your child's public benefits or insurance to pay for special education and related services under IDEA.

Contact information: For additional information and guidance on the requirements governing the use of public benefits or insurance to pay for special education and related services see: http://www2.ed.gov/policy/speced/reg/idea/part-b/part-b-parentalconsent.html

MEDICAID CONSENT

(Insert district information)

Dear Parent/ Guardian of _____:

This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's Individualized Education Program (IEP). This consent allows the School District/Nassau County to bill for covered health-related services and to release information to the school district's Medicaid Billing Agent for that purpose. **I, _____as the parent/guardian of _____,**

(Print child's name)

have received a written notification from the School District that explains my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District/ Nassau County may access Medicaid to pay for special education and related services provided to my child.

I understand that: providing consent will not impact my child's/my Medicaid coverage; upon request, I may review copies of records disclosed pursuant to this authorization; services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid; I have the right to withdraw consent at any time; and the School District must give me annual written notification of my rights regarding this consent.

I also give my consent for the School District/ Nassau County/ Providers to release the following records/information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP. The following records will be shared.

Records to be shared (such as records or information about services your child receives)	
Prescription	Service Provider Attendance
Referral	"Under the Direction of" Certification
Treatment Logs	"Under the Supervision of" Certification
Individualized Education Program - IEP	"Under the Direction of" Logs
Attendance Records	"Under the Supervision of" Logs
Bus Logs	Calendar
Other unnamed documents needed to support a claim to Medicaid	

MEDICAID/CIN # - _____

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

05-25-18

CONSENTIMIENTO DE MEDICAID

(Insert District Information)

Estimado Padre/Guardian de _____:

Esto es para solicitar su permiso (autorización) para fracturar a su or su niño, el seguro de Medicaid para el programa de educación especial y servicios relacionados que se encuentran en el programa de educación individualizada (IEP) de su niño. Este acuerdo permite que, el Distrito Escolar/Nassau County fracture servicios relacionados.

Yo, _____ como padre/guardian de _____,
(Imprime nombre de su niño)
acabo de recibir una notificación por escrito del Distrito Escolar que explica mi derechos federales con respecto a la utilización de beneficios público o seguros que pagan ciertos programas de educación especial y servicios relacionados.

Entiendo y estoy de acuerdo que el distrito escolar/Nassau County puede acceder a Medicaid para que paguen por la educación especial y servicios relacionados de mi niño. Entiendo que: en dar mi consentimiento, no le afectara el seguro de Medicaid de mi niño ; cuando quiero, puedo revisar las copias de los registros/documentos transmitido en virtud de esta autorización; servicios que estan indicado en el IEP de mi niño deben ser proporcionado sin costo a mí, si estoy en acuerdo o no permito dar mi consentimiento a Medicaid; tengo el derecho de retirar mi consentimiento en cualquier momento ; y el Distrito Escolar debe mandar (cada año), notificación por escrito sobre mis derechos con respecto a este consentimiento. Yo también doy mi consentimiento para que el Distrito Escolar/ Nassau County/ Provider mande los registros siguientes/información sobre mi niño, a la Agencia de Medicaid del Estado de Nueva York, para que facturen programas de educación especial y servicios relacionados que están indicado en el IEP de mi niño. Los registros siguientes serán compartidos.

Registros compartidos (registros/informacion sobre servicios que su niño recibe)	
Prescription	Service Provider Attendance
Referral	“Under the Direction of” Certification
Treatment Logs	“Under the Supervision of” Certification
Individualized Education Program - IEP	“Under the Direction of” Logs
Attendance Records	“Under the Supervision of” Logs
Bus Logs	Calendar
Other unnamed documents needed to support a claim to Medicaid	

MEDICAID/CIN # - _____

Doy mi consentimiento voluntario y entiendo que puedo retirar mi consentimiento en cualquier momento. Tambien tengo entendido que en mi niño teniendo el derecho de recibir educación especial y servicios relacionados, en ninguna manera depende en mi autorización y que, a pesar de mi decisión de proporcionar este consentimiento, todos los servicios requeridos en el IEP de mi niño, será siempre ofrecido a mi niño sin algun costo a mí.

Firma de Padre/Madre: _____

Nombre de Padre/Madre: _____ Fecha: _____

Nassau County Department of Health Services **APPENDIX J**
Preschool Special Education Program

NOTIFICATION OF EXTENDED NON-DELIVERY OF SERVICES
(6 or more Consecutive Missed Sessions)

TO: _____
Name of CPSE Chairperson

_____
School District

_____
Address of School District

FROM: _____
Provider's Name and Discipline

_____
Agency/School Name

_____
Address of Agency/School

Phone Number: _____ Fax Number: _____

Date of Notification: _____

Student's Name: _____

Date of Birth: _____

Dates of missed sessions	**Reason for missed sessions**
1. _____/_____/_____	_____
2. _____/_____/_____	_____
3. _____/_____/_____	_____
4. _____/_____/_____	_____
5. _____/_____/_____	_____
6. _____/_____/_____	_____

Return date, if applicable: _____

With parental permission, makeup sessions should be done within two calendar weeks from the session being missed for Related Services. In cases of SEIT absence, a makeup session is required when the SEIT is absent unless the parent(s) objects and must be provided within 30 days unless documented child-specific reason.

Nassau County Department of Health
Preschool Special Education Program FAX- 516 227-8666

APPENDIX K

Nassau County Department of Health
Preschool Special Education Program FAX- 516 227-8666

NASSAU COUNTY
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
60 Charles Lindbergh Blvd. Suite 100
Uniondale, New York 11553-3683

The Functional Assessment Interview (School Version)

Name of Student : _____ **Date of Birth** : _____

Today's Date:_____ **Name of School :**_____

Teacher: (Indicate name and title of person completing this form)_____

# of children in class: _____ student/teacher ratio: _____ age range:_____

What is the role of teacher assistants/aide? _____
_____
_____

DESCRIBE THE BEHAVIOR(S)

What are the behaviors of concern? For each, define the setting, frequency (how often it occurs per day, week, or month), duration (how long it lasts when it occurs), and intensity (what is the *magnitude* of the behaviors [low, medium, high] Does it cause harm?).

1. **Behavior:** _____

   Setting: _____ Frequency: _____

   Duration: _____ Intensity: _____

2. **Behavior:** _____

   Setting: _____ Frequency: _____

   Duration: _____ Intensity: _____

3. **Behavior:** _____

   Setting: _____ Frequency: _____

Duration: _____ Intensity: _____

History of Problem Behavior

1. When did the problem behavior(s) begin? Do any of the behaviors listed above occur together (that is, occur at the same time or in response to the same stimulus or situation, or under the same circumstances?)

_____

_____

_____

_____

_____

2. Are there times/places/individuals present, when/where the problem behavior always occurs? Are there certain types of situations/activities that are particularly problematic for the student?

_____

_____

_____

_____

_____

_____

3. Are there times/places when/where the problem behaviors never or rarely occur?

_____

_____

_____

_____

4. Is the problem behavior related to skill deficits? If so, please describe.

_____

_____

_____

_____

5. What medical conditions, if any, does the student have that may affect his/her behavior (such as seizures, allergies, asthma, etc.)? Is the student taking any medication that might affect his/her behavior?

_____

_____

_____

_____

6. What have been the responses to the problematic behavior? What reinforcers have been effective with the student?

_____

_____

_____

_____

_____

_____

_____

_____

7. Do you have any additional comments about this student or about the problem behavior?

_____

_____

_____

_____

_____

NASSAU COUNTY
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
60 Charles Lindbergh Blvd. Suite 100
Uniondale, New York 11553-3683

The Functional A ssessment Interview (Family Version)

Name of Student : _____ **Date of Birth** : _____

Interviewer: _____ **Date of Interview :** _____

Respondent(s) : (Indicate name and relationship with child of individual completing this form)

_____ _____

DESCRIBE THE BEHAVIOR(S)

What are the behaviors of concern? For each, define the setting, frequency (how often it occurs per day, week, or month), duration (how long it lasts when it occurs), and intensity (what is the *magnitude* of the behaviors [low, medium, high] Does it cause harm?).

1. **Behavior:** _____

   Setting: _____ Frequency: _____

   Duration: _____ Intensity: _____

2. **Behavior:** _____

   Setting: _____ Frequency: _____

   Duration: _____ Intensity: _____

3. **Behavior:** _____

   Setting: _____ Frequency: _____

Duration: _____ Intensity: _____

4. **Behavior:** _____

Setting: _____ Frequency: _____

Duration: _____ Intensity: _____

History of Problem Behavior

1. When did the problem behavior(s) begin? Do any of the behaviors listed above occur together (that is, occur at the same time or in response to the same stimulus or situation, or under the same circumstances?)

_____

_____

_____

_____

_____

2. How often does the problem behavior occur? How long does it typically last? What is the magnitude or intensity of the problem behavior?

_____

_____

_____

_____

_____

3. Are there times/places when/where the problem behavior always occurs? Are there certain types of situations/activities that are particularly problematic for the student?

_____

_____

_____

_____

_____

4. Are there times/places when/where the problem behaviors never or rarely occur?

_____

_____

_____

_____

_____

5. Does the problem behavior occur only when the student is with certain people? Does the amount of people present during interactions affect the problem behavior?

_____

_____

_____

_____

_____

6. Is the problem behavior related to skill deficits? If so, please describe.

_____

_____

_____

_____

7. Are there any observable events that signal that the problem behavior is about to occur?

_____

_____

_____

_____

8. What medical conditions, if any, does the student have that may affect his/her behavior (such as seizures, allergies, asthma, etc)? Is the student taking any medication that might affect his/her behavior?

_____

_____

_____

_____

_____

_____

_____

9. What is the student's typical sleep pattern? How many hours a night does the student typically sleep? What is the student's typical eating pattern?

_____

_____

_____

_____

_____

_____

_____

_____

10. What have been the responses to the problematic behavior?

_____

_____

_____

_____

11. What are the student's interests? What reinforcers have been effective with the student?

_____

_____

_____

_____

12. Do you have any additional comments about this student or about the problem behavior?

_____

_____

_____

NASSAU COUNTY
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
60 Charles Lindbergh Blvd. Suite 100
Uniondale, New York 11553-3683

Date:

Child's name: _____ DOB: _____

Functional Behavior Assessment (FBA) Checklist

_____ Provider has obtained signed parental consent to conduct/develop an FBA/BIP

The FBA includes:

_____ Target behaviors defined in observable, measurable terms

_____ A structured parent interview (Functional Assessment Interview Family Version)

_____ A structured teacher interview (Functional Assessment Interview School Version)

_____ A structured observation

_____ Systematic data collection (by Preschool teacher and psychologist or special education teacher) (ABC Checklist)

_____ A review of written records/previous intervention strategies used to address problematic behavior

_____ Antecedent events and consequences surrounding the child's target behaviors have been identified

_____ The frequency/duration/intensity level of the child's target behaviors have been identified

_____ Contextual factors that contribute to the target behavior (including cognitive and affective factors) have been identified

_____ Environmental factors that contribute to the target behavior have been identified

_____ The function or purpose of the target behaviors has been identified (note: there may be more than one function)

_____ A hypothesis has been developed (When X occurs, the child does Y in order to Z)

*** When all of these are checked, SED requirements have been met**

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APPENDIX L

NASSAU COUNTY
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program
60 Charles Lindbergh Blvd. Suite 100
Uniondale, New York 11553-3683

Date:

Child's name: _____ DOB: _____

Behavior Intervention Plan (BIP) Checklist

The BIP includes:

_____ Background information

_____ Target behaviors (including operational definitions)

_____Hypothesized function(s) of target behavior(s)

_____ Desired outcomes/goals (operationally defined)

_____ Proactive/antecedent based intervention strategies (including environmental adaptations)

_____ Reactive/consequence based intervention strategies

_____ Criteria to measure progress

_____ A schedule (at regular intervals*) to measure the effectiveness of the interventions**

_____ The BIP is signed by all appropriate participants (provider, parent, teacher or staff member)

* 8-12 weeks is best practice and strongly suggested

** one method to measure effectiveness of the BIP is the ABC checklist completed by the Preschool teacher/daycare provider and psychologist or SEIT

APPENDIX M

NASSAU COUNTY DEPARTMENT OF HEALTH PRESCHOOL SPECIAL EDUCATION PROGRAM

TIMESHEET FOR NURSING TRANSPORTATION SERVICES ON THE SCHOOL BUS - 2022-2023

NAME OF STUDENT: DROP-OFF LOCATION:

NAME OF AGENCY: NURSE'S NAME: RN:_____LPN:_____

LPN must use a separate time sheet

APPROVING SCHOOL DISTRICT: WEEK OF:

(mm/dd/yy) - (mm/dd/yy)

DAILY HOURS APPROVED BY DISTRICT/PER IEP: Any unusual delays or problems should be noted in "Comments" column of the form.

DATE OF SERVICE	PICK-UP TIME AT HOME	PARENT'S INITIALS	DROP-OFF TIME AT SCHOOL	SCHOOL CONTACT INITIALS	PICK- UP TIME AT SCHOOL	SCHOOL CONTACT INITIALS	DROP-OFF TIME AT HOME	PARENT'S INITIALS	MUST INDICATE ROUND TRIP HOURS	COMMENTS

I hereby certify that the list of services provided on this form is a true and accurate representation of the facts and that all services were in compliance with the laws and agreements governing the Preschool Supportive Health Services Program. If any of the above services were provided by an LPN, then I further attest that proper supervision has been provided as per each discipline's Practice Acts and all applicable laws. I am aware that deliberate filing of false information may result in criminal penalties.

SUPERVISOR SIGNATURE FOR LPN: DATE:

** Supervisor's signature required if above initialed by an LPN

SIGNATURE OF AGENCY REPRESENTATIVE: DATE:

SIGNATURE of PARENT/GUARDIAN: DATE

NASSAU COUNTY DEPARTMENT OF HEALTH - PRESCHOOL SPECIAL EDUCATION PROGRAM
NURSE ON THE BUS - TRANSPORTATION CLAIM SUMMARY

Service Provider: _____

Voucher Number: _____ **Service: Nurse on the Bus**

Please use a 4 character to 10 (max) character voucher numbering system (letters/numbers may be used)

STUDENT NAME	WEEKS 1-5	IEP APPROVED DAILY HOURS	TOTAL WEEKLY HOURS BILLED	SERVICE PERIOD FROM	SERVICE PERIOD TO	AMOUNT CLAIMED		DOH APPROVED AMOUNT
	1				-			
	2				-			
	3				-			
	4				-			
	5				-			
					-			
					-			
					TOTAL			

AUTHORIZED CLAIMANT'S SIGNATURE

AUDITOR:

DATE:

03/2022

Your District Address
Your District Address
Your District Address

Your District Phone Number with extension
Your District FAX Number
Date Sent to NCDOH_____ Initials_____

NASSAU COUNTY DEPARTMENT OF HEALTH NOTIFICATION FORM
COMMITTEE FOR PRESCHOOL SPECIAL EDUCATION
RELATED AND/OR SPECIAL EDUCATION ITINERANT TEACHER (SEIT) SERVICES – ATD

1) Child Demographics:

Transfer Student from: _____

INITIAL: Y / N (Circle one – Birth Certificate Required with Initial submissions) **CPSE EVAL OUT OF COUNTY: Y / N** (Circle one)

CHILDS NAME:		M:	F:	DOB:
ADDRESS:	TOWN:	***ZIP:***		***(Must Include Zip Code)***
PARENT/GUARDIAN NAME:		PHONE:		
Foster Placement: Y / N	County at Time of Foster Care Placement :	Agency Name:		
Agency Address:		Agency Phone:		

2) Has this child been diagnosed with Autism Spectrum Disorder (ASD)? Must Circle one. ASD Yes / No

3) ATD (Assistive Technology Device):

Device: Supplier:

4) List of Related Services with an NYSED Approved Rate (*Only these Related Services may be written on a STAC-1***)**

Assistive Technology. Services	Audiology	**Coordinator of RS**	Psychological Counseling Services	Occupational Therapy	Orientation & Mobility
Parent Counseling & Training	Physical Therapy		School Health Service/Nurse	School Social Work	Speech Therapy
Teacher of the Hearing Impaired	Teacher of the Visually Impaired	Certified Teacher Assistant	Teacher Aide	1:1 Aide (not in a center based program)	

5) NYSED SEIT Program Code – 9135 S or 9136 S – Fill-in program code in section 10 on STAC-1

6) CPSE Chair Signature _____ **Date**_____

See attached STAC-1

AMENDMENT#: _____ of _____ Amendment Date: _____

APPENDIX O

1st Request

Date of First Request: _____

Date of Second Request: _____

Nassau County
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Early Intervention Program
Preschool Special Education Program
Physically Handicapped Children's Program
60 Charles Lindberg Blvd, Suite 100
Uniondale, NY 11553-3683

Requests for Research submitted less than 35 calendar days from date of the CPSE Meeting at which the evaluations were reviewed will not be conducted.

Provider STAC-5 Research Request

Provider Name
Provider Address 1
Provider Address 2
City, State Zip

Provider Phone Number
Provider Fax number
Person making this request

Session

School District Name

Chairs will not create STAC-5's for any evaluations that were not authorized in advance and in writing by the District's CPSE Department.

Provider Instructions (personalize above sections in green):

1. **Review the NYSED STAC Online website to determine if an evaluation was already approved by NYSED prior to completing this request.**
2. **Enter the session during which the evaluation to be researched was conducted above. One session per request.**
3. **Enter the name of the school district that authorized the evaluation. One district per request.**
4. **Fill in all of the required information below.**
5. **Attach a copy of the Evaluation Authorization, Evaluation Verification and if applicable Parental Consent for Bilingual Evaluation.**
   Note Research will not be conducted without these forms attached.
6. **Mail the first request of the *Provider STAC-5 Research Request* and supporting documents to the to the CPSE Chair of the district that authorized the evaluations and who will conduct the research. If a second request is necessary, in addition to sending the second request to the CPSE Chair and Director of Pupil Personnel Services, send a copy of the *Provider STAC-5 Research Request Form* with the supporting documents to the NCDOH STAC Unit at the address and suite above, *Attention:* STAC-5 Research.**

School District CPSE Chair's Instructions:

1. **Compare *Provider STAC-5 Research Request* and supporting documents to the student's record.**
2. **Determine if a STAC-5 was not prepared or if a resubmission, an amendment or research denial letter is required.**
3. **Submission of STAC-5 Packet or Letter of Denial:**
   a. **If there is no STAC-5 Packet in the student's record, prepare a new STAC-5 Packet and include the child's birth certificate (for initial evaluations), the Evaluation Verification, Parental Consent for Bilingual Evaluation (if necessary) and any required NYSED Letters of Explanation. Send the entireSTAC-5 Packet to the NCDOH STAC Unit.***
   b. **If a STAC-5 Packet is in the student's record, a resubmission is required. Make any necessary amendments; copy the entire STAC-5 Packet, supporting documents and any NYSED required Letters of Explanation. Send the STAC-5 Packet to the NCDOH STAC Unit.***

c. **If the request for research or preparation of the STAC-5 is being denied, prepare a letter explaining why the request was denied. This letter of denial must be sent to the NCDOH STAC Unit *and* to the provider along with a copy of this request form.**

***NOTE: Review the STAC-5 Packets prior to submission or resubmission to ensure all information on the STAC-5 has been completed. STAC-5's missing the NYSED required information, Evaluation Verifications and Letters of Explanation and/or Parental Consent for Bilingual Evaluation (if applicable) can not be data entered, and will be returned to your office for correction.**

4. **In the last column of the *Provider STAC-5 Research Request,* fill in the date the STAC-5 issue was resolved and the STAC-5 Packet or denial letter was mailed to the NCDOH STAC Unit. When all of the students' issues have been resolved, fax a copy of the completed *Provider STAC-5 Research Request* and any letters of denial to the provider.**
5. **Chairs are requested to complete this process *within 10 business* days of receiving the *STAC-5 Research Request Form* from the provider.**

	Student Name	Child's Date of Birth	CPSE Meeting Date (Must be filled in)	Evaluation Type	Letter of Explanation Required Yes/No	Date of Evaluation	Bilingual Evaluation Authorized	Parental Bilingual Consent is attached	Evaluation Authorization and Evaluation Verification is attached	Date CPSE resolved request and STAC-5 sent to the NCDOH STAC Unit or the request was denied by the CPSE Chair
	E.g. John Smith	**12/15/04**	**12/01/07**	**Speech**	**No**	**10/17/07**	**Yes**	**Yes**	**Yes**	**01/28/2008**
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

APPENDIX P

Nassau County
DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Early Intervention Program
Preschool Special Education Program
Physically Handicapped Children's Program
60 Charles Lindberg Blvd, Suite 100
Uniondale, NY 11553-3683

1st Request

Date of First Request: _____

Date of Second Request: _____

Provider STAC-1 Research Request

Requests for Research submitted *less than 35 calendar days* from the start date of Center Based, SEIT or Related Services will not be conducted.

Provider Name
Provider Address 1
Provider Address 2
City, State Zip

Provider Phone Number
Provider Fax number
Person making this request

Research requests for Related Services that do not have a rate set by Nassau County will not be conducted.

Session

School District Name

Provider Instructions (personalize above sections in green):

7. **Review the Provider Confirmation Notification prior to completing this request.**
8. **Enter the session in which the services were provided for which research is requested. One session per request.**
9. **Enter the name of the school district that authorized the Center Based, SEIT and/or Related Services. One district per request.**
10. **Fill in the required information below.**
11. **Attach a copy of the IEP and when applicable, the district notification naming you as the provider of service. Indicate on the IEP which program and/or services for which you are requesting research and are not on the Provider Confirmation Notification or are in need of amendment.**

Note Research will not be conducted without the required form(s) attached.

12. **Mail the first request of the *Provider STAC-1 Research Request* and supporting documents to the to the CPSE Chair of the district that authorized the services and who will conduct the research. If a second request is necessary, in addition to sending the second request to the CPSE Chair and Director of Pupil Personnel Services, send a copy of the *Provider STAC-1 Research Request Form* with the supporting documents to the NCDOH STAC Unit at the address and suite above, *Attention:* STAC-1 Research.**

School District CPSE Chair's Instructions:

6. **Review the Provider Confirmation Notification and compare it to the supporting documents submitted by the provider prior to researching this request.**
7. **Review the student's record and determine if a STAC-1 is missing, is in need a resubmission or if an amendment is required.**
8. **Submission of STAC -1 Packet or Letter of Denial:**
    a. **If no STAC-1 or amendment is in the student's record, prepare the STAC-1 or the amendment. Prepare a County Notification Form and send the STAC-1 Packet to the NCDOH STAC Unit.**

b. If the STAC-1 or amendment was prepared, resubmission is required. Make a copy of the back and front STAC-1, prepare a County Notification Form and submit the STAC-1 Packet to the NCDOH STAC Unit.

c. If the request for research or preparation of the STAC-1 is being denied, prepare a letter explaining why the request was denied. This must be sent to the NCDOH STAC Unit *and* to the provider along with a copy of this request form.

9. In the last column, fill in the date the STAC-1 issue was resolved and the STAC-1 or denial letter was mailed to NCDOH STAC Unit.

10. When all of the students' issues have been resolved, fax a copy of the completed *Provider STAC-1 Research Request* and any denial letters to the provider.

11. Chairs are requested to complete this process *within 10 business* days of receiving the *STAC-1 Research Request Form* from the provider.

	Student Name	Child's Date of Birth	Program Type	Service Type (Note: Parent Training by a SEIT is part of Total SEIT hours.)	Frequency and Duration	Group or Individual	Start Date	End Date	IEP and/or district notification naming you as the provider of service is attached	Date CPSE resolved the request and STAC-1 sent to the NCDOH STAC Unit or request was denied by CPSE Chair
	Example: John Smith	**12/01/2003**	**CB**	**Special Class Full Day 9100I**	**5hrs x 5 days/wk**	**n/a**	**9/06/07**	**6/22/08**	**YES**	**10/15/07**
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

APPENDIX Q

CLAIMANT: Fill out only those areas printed in red. SEE reverse side for instructions.

COUNTY OF NASSAU

CLAIM VOUCHER

INVOICE NUMBER

①

DOCUMENT #

(FOR NASSAU COUNTY DEPARTMENT USE ONLY)

ORDER/CONTRACT NO.

②

BLANKET ORDER NO.

③

VENDOR INFORMATION: NUMBER (9) SUFFIX (2)

④ ⑤

NAME (30) ⑥

(30)

ADDR (30) ⑦

(30)

(30)

DISCOUNT AMOUNT

DISCOUNT DATE MO (2) DY (2) YR (2)

CLAIMANTS CERTIFICATION

I hereby certify that this claim voucher is just, true, and correct; that the amount claimed is actually due and owing and has not been previously claimed; that no taxes from which the County is exempt are included; and that any amounts claimed for disbursements have actually and necessarily been made. I further certify that all items and/or services were delivered or rendered as set forth in this claim, and for all items and/or services delivered or rendered in accordance with a purchase order or contract that the prices charged are in accordance with the reference purchase order or contract. For all claims made as reimbursement for employee expenses, I further certify that the amounts set forth were actually and necessarily expended for the benefit of Nassau County, and that the monies expended have not been reimbursed nor do I expect to be reimbursed from any source.

⑧

Claimants Name Date

X

By (Signature) Title

DEPT. GOODS OR SERVICES DELIVERED TO ⑨

VENDOR'S PAYMENT TERMS ⑩

⑪ DATE DELIVERED	ITEMIZATION	UNIT PRICE	AMOUNT
		⑫ TOTAL CLAIMED ▶	

For Nassau County Department Use Only:

NIFS ACCOUNT CODES *Please note that only one invoice is payable per claim voucher. The invoice may be charged to more than one account code.*

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
1										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - *invoice no. or claim no.* description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
2										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - *invoice no. or claim no.* description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
3										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - *invoice no. or claim no.* description

LINE #	INDEX	SUBOBJ	USERCODE	PROJECT	PROJDETAIL	GRANT	GRTDETAIL	G/L ACCOUNT	SUBSIDIARY	AMOUNT
4										

INVOICE NO or CLAIM NO and DESCRIPTION (50):

FORMAT - *invoice no. or claim no.* description

NC Department _____ **Amount Approved $** _____

Contact Person _____ **Date** _____

Telephone No. _____ **Comptrollers Approval** _____

FORM NIFS560.11/98 NCPG

COMPTROLLER COPY

CO-155-A.3/98 REV. 10/00

APPENDIX R

NASSAU COUNTY DEPARTMENT OF HEALTH
PRESCHOOL SPECIAL EDUCATION PROGRAM

60 Charles Lindbergh Boulevard, Suite 100 Uniondale, NY 11553
Telephone (516) 227-8674 Fax (516) 227-7147

REQUEST & AUTHORIZATION TO PURCHASE ASSISTIVE TECHNOLOGY EQUIPMENT

REQUESTED FOR:

Child's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Telephone: _____

Address: _____ Medicaid #: _____

SCHOOL DISTRICT AUTHORIZATION:

District: _____ Telephone: _____

Address: _____

CPSE Chairperson: _____ Signature: _____

PLEASE TYPE OR PRINT NAME **CPSE CHAIRPERSON**

Evaluation Site: _____ Telephone: _____

VENDOR INFORMATION:

Vendor Name: _____

Address: _____

Contact Person: _____

Telephone: _____ Fax No.: _____

Requested Device: (Detailed description required)

_____

_____

_____

Device is to be Delivered To: _____

GIVE COMPLETE ADDRESS

NASSAU COUNTY DEPARTMENT OF HEALTH AUTHORIZATION - DOH USE ONLY

Date Authorized: _____ By: _____

Student ID No.: _____ Date Ordered: _____ Price: _____

Date Delivered: _____ Voucher No.: _____ Date Paid: _____

DATE OF TRANSITION TO CSE: _____

NOTE: The following must be attached to this request:
IEP, evaluation report, STAC 1, Nassau County DOH Notification form, and price quotation from the suggested assistive technology vendor

INCOMPLETE FORMS WILL NOT BE CONSIDERED FOR REVIEW AND WILL BE RETURNED TO THE SCHOOL DISTRICT ONLY
ORIGINAL SIGNATURES WILL BE ACCEPTED. No FAXES or COPIES.

Preschool Assistive Technology Device (ATD)
School District Worksheet

Child's Name:		DOB:	
Date 1st reviewed:		Last Eligible CPSE:	
School District:		First Eligible Preschool:	
Evaluation by:		Date of Eval:	
Justification by:		Type of ATD:	
Child Placement:		Price:	

Date obtained	**Items required completing the order. Must be originals** – ***<u>do not fax</u>***
	STAC 1
	Request and Authorization to Purchase Assistive Technology Equipment Form (PS 4007 - to be filled out by the school district)
	Quotation from assistive technology vendor (on vendor letterhead-therapist obtains)
	Individualized Education Program (IEP) – must state ATD
	NCDOH RS-SEIT ATD County Notification Form (PS 2002)
	Evaluation/justification for ATD (either one)
	When an evaluation is done:
	STAC 5 (both sides of form)
	Evaluation Verification Form
	Doctor's RX for device – *must be original*
	Letter on district letterhead stating the device was received by the district, the order was complete and the ATD was given to the student.
Date Mailed to NCDOH	
	Original ATD order mailed to: Nassau County Department of Health Office of Children with Special Needs Preschool Special Education Program Attention: Cathy Langdon 60 Charles Lindbergh Boulevard, Suite 100 Uniondale, NY 11553-3683
Notes:	

Preschool Assistive Technology Device (ATD) - Worksheet

Child's Name:		DOB:
Date 1st reviewed:		Last Eligible CPSE:
School District:		First Eligible Preschool:
Evaluation by:		Date of Eval:
Justification by:		Type of ATD:
Child Placement:		Price:
Date obtained from SD:	(**Items required completing the order. Must be originals** – ***do not fax***)	
	STAC 1	
	Request and Authorization to Purchase Assistive Technology Equipment Form (PS 4007 - to be filled out by the school district)	
	Quotation from assistive technology vendor (on vendor letterhead- therapist obtains)	
	Individualized Education Program (IEP) – must state ATD	
	NCDOH RS-SEIT ATD County Notification Form (PS 2002)	
	Evaluation/justification for ATD (either one)	
	When evaluation is done: STAC 5 (both sides of form)	
	Evaluation Verification Form	
	Doctor's RX for device – *must be original*	
	Letter on district letterhead stating the device was received by the district, the order was complete and the ATD was given to the student.	
Vendor section:	Date letter sent to vendor	
	If item is appropriate to order and the above items have been received, place order with authorized vendor	
	Send letter and include claim voucher for payment + 700 form if needed CC: CPSE Chair Parent Fiscal Staff, Laura McCool Any other pertinent individual (therapist, school) – done infrequently	
	Items needed for the payment of the invoice:	
	Signed claim voucher	
	Invoice	
	Receipt	
	Notification form	
	At time of payment, STAC 1 and Request & Authorization to Purchase ATD Equipment for is sent to: NYS Education Department Program Services Unit (CST #3) One Commerce Plaza - Room 1624 Albany, New York 12234 Attention: Sheila Costa	
	Claim is entered as a VMHE	
	Use HEGEN%$)) as the index	
	Use PP757 as the subject	
Date claim and paperwork to Fiscal:		
Notes:		

Your District Name
Your District Address
Your District Address
Your District Address

Your CPSE Chair's Name
Your District Phone Number with extension
Your District FAX Number
Date Sent to NCDOH_____ Initials_____

NASSAU COUNTY DEPARTMENT OF HEALTH NOTIFICATION FORM
COMMITTEE FOR PRESCHOOL SPECIAL EDUCATION
RELATED AND/OR SPECIAL EDUCATION ITINERANT TEACHER (SEIT) SERVICES – ATD

1) Child Demographics:

Transfer Student from: _____

INITIAL: Y / N (Circle one – Birth Certificate Required with Initial submissions) **CPSE EVAL OUT OF COUNTY: Y / N** (Circle one)

CHILDS NAME:		M:	F:	DOB:
ADDRESS:	TOWN:	***ZIP:***		***(Must Include Zip Code)***
PARENT/GUARDIAN NAME:		PHONE:		
Foster Placement: Y / N	**County at Time of Foster Care Placement :**	**Agency Name:**		
Agency Address:		**Agency Phone:**		

2) Has this child been diagnosed with Autism Spectrum Disorder (ASD)? Must Circle one. ASD Yes / No

3) ATD (Assistive Technology Device):

Device: _____ Supplier: _____

4) List of Related Services with an NYSED Approved Rate (*Only these Related Services may be written on a STAC-1***)**

Assistive Technology. Services	Audiology	**Coordinator of RS**	Psychological Counseling Services	Occupational Therapy	Orientation & Mobility
Parent Counseling & Training	Physical Therapy		School Health Service/Nurse	School Social Work	Speech Therapy
Teacher of the Hearing Impaired	Teacher of the Visually Impaired	Certified Teacher Assistant	Teacher Aide	1:1 Aide (not in a center-based program)	

5) NYSED SEIT Program Code – 9135 S or 9136 S – Fill-in program code in section 10 on STAC-1

6) CPSE Chair Signature _____ **Date**_____

See attached STAC-1

AMENDMENT#: _____ of _____ Amendment Date: _____

APPENDIX S

NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program

QUARTERLY PROGRESS REPORT
RELATED SERVICE
GUIDANCE INSTRUCTIONS

Name of Student:	Chronological Age: Student's Date of Birth:
Date of Report:	Related Service Provider:
Related Service:	Provider Agency (if applicable):
School District:	IEP Dates of Service:

Goals(s)/Objectives(s):

1. **List or attach copy of the goals and objectives.**
2. **Indicate status toward goal acquisition (e.g., achieved, some progress, progressing satisfactorily, not started)**

Summary of Progress:

1. **Include a narrative statement discussing the child's current level of functioning including strengths, continuing needs, and progress achieved.**
2. **Describe progress toward goals including factors influencing child's progress including attendance, parent involvement, and classroom teacher involvement.**
3. **Include a narrative statement describing communication with the classroom teacher and parents.**
4. **If you are the Coordinator of Services, provide a statement reviewing your communication and activities with all other service providers and parents.**
5. **If there is evidence concerning a child's regression, describe the regression and provide data.**

Conclusions and Recommendations:

1. **List all other services received by child and family.**
2. **Based on summary of child's assessments, current level of functioning and observations, write a statement that sums up child's strengths and continuing needs or concerns.**
3. **Recommendations only if required by your Practice Act. Do not include frequency and duration.**
4. **Recommendations for any additional evaluations must be discussed with your supervisor and then with the CPSE Chair. The CPSE Chair may require a separate written rationale.**
5. **Any discussion about a child must involve the parent or guardian.**

Date Signature of Related Service Provider Title

CC: Student's CPSE Chairperson
Parents/Guardians

NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program

QUARTERLY PROGRESS REPORT
SEIT SERVICE
GUIDANCE

Name of Student:	Student's Date of Birth:
Date of Report:	Chronological Age:
SEIT Provider Name:	Agency/School Name:
School District:	IEP Dates of Service:

Goals(s)/Objectives(s):

List or attach copy of the goals and objectives.

1. **Indicate status toward goal acquisition (e.g.., achieved, some progress, progressing satisfactorily; not started)**
2.

Summary of Progress toward Goals(s) and Objective(s):

1. **Include a narrative statement discussing the child's current level of functioning including strengths, continuing needs, and progress achieved.**
2. **Describe progress toward goals including factors influencing child's progress including attendance, parent involvement, and classroom teacher involvement.**
3. **Include a narrative statement describing communication with the classroom teacher and parents.**
4. **If you are the Coordinator of Services, provide a statement reviewing your communication and activities with all other service providers and parents.**
5. **If there is evidence concerning a child's regression, describe the regression and provide data.**

Conclusions and Recommendations:

List all other services received by child and family.

1. **Based on summary of child's assessments, current level of functioning and observations, write a statement that**
2. **sums up child's strengths and continuing needs or concerns.**
3. **Service type, frequency, duration and location are determined by the CPSE, and therefore, should not be included in the report.**
4. **Recommendations for any additional evaluations must be discussed with your supervisor and then with the CPSE Chair. The CPSE Chair may require a separate written rationale.**
5. **Any discussion about a child must involve the parent or guardian.**

Signature of SEIT Provider Date

CC: Student's CPSE Chairperson
Parents/Guardians

APPENDIX T

NASSAU COU NT OF HEALTH
OFFICE OF CH PECIAL NEEDS
Preschool on Program

ANNUAL REVIEW PROGRESS REPORT
RELATED SERVICE
GUIDANCE

Name of Student:	Chronological Age: Student's Date of Birth:
Date of Report:	Related Service Provider:
Related Service:	Provider Agency (if applicable):
School District:	IEP Dates of Service:

Assessments Administered (Formal/Informal): Assessment Scores/Results:*

1. **List of observation and assessment tools**
2. **Completed by treating therapist during a scheduled session**

Date of Assessment Type of Assessment

_____ _____

_____ _____

Current level of functioning: Must include objective data (could be age equivalent score, percentile score or standard deviations)

Summary of Assessment Results and progress toward Goal(s) and Objectives(s):

1. **Include a narrative statement discussing the child's current level of functioning including strengths, continuing needs, and progress achieved.**
2. **Describe progress toward goals including factors influencing child's progress including attendance, parent involvement, and classroom teacher (if applicable) involvement.**
3. **Summarize child's progress from initiation of current IEP services to the present.**
4. **Include a narrative statement describing communication with the classroom teacher (if applicable) and parents. If you are the Coordinator of Services, provide a statement reviewing your communication and activities with all other service providers and parents.**
5. **If there is evidence concerning a child's regression, describe the regression and provide data.**

Conclusions and Recommendations:

1. **List all other services received by child and family.**
2. **Based on summary of child's assessments, current level of functioning and observations, write a statement that sums up child's strengths and continuing needs or concerns.**
3. **Recommendations only if required by your Practice Act. Do not include frequency and duration.**
4. **Recommendations for any additional evaluations must be discussed with your supervisor and then with the CPSE Chair prior to the Annual Review Meeting. The CPSE Chair may require a separate written rationale.**
5. **Any discussion about a child must involve the parent or guardian.**

Date Signature of Related Service Provider Title

CC: Student's CPSE Chairperson
Parents/Guardians

Annual Review Progress Report
Center-Based Programs

The CPSE Issues Training Sub-Committee developed the protocol below in an effort to standardize the content of annual review reports for children in center-based programs. Individual programs can use their own format that incorporates the following information.

- **Demographic information should include the following:**

<table>
<tr><td>Name of Student</td><td colspan="2">Student's Date of Birth</td></tr>
<tr><td>Date of Report</td><td colspan="2">Student's Age</td></tr>
<tr><td rowspan="2">Classroom Teacher</td><td>Class Hours</td><td rowspan="2">Class Ratio</td></tr>
<tr><td>Days per Week
M T W Th F</td></tr>
<tr><td>Student's School District</td><td colspan="2">IEP Dates of Service</td></tr>
</table>

- **<u>Background/Introductory paragraph</u> which includes length of time in program and services currently received.**
- **Assessments Administered (Formal/Informal)**
  - **Completed by classroom teacher**
  - **List of observation and assessment tools**
  - **Assessment scores/results***
    ***Must include objective data (e.g., age equivalent score, percentile score or standard deviation)**
- **Include a narrative statement discussing the child's current level of functioning in all areas of development (5 domains) including strengths, continuing needs, and progress achieved. This information can be used in the SPAMs on the IEP.**
  - **Include a narrative statement describing the child's functioning in the classroom environment.**
  - **Include a narrative statement describing the interventions implemented in the classroom.**
  - **Describe progress toward goals**
  - **If there are any behavioral issues and a BIP is in place, a narrative statement describing the child's response to the BIP must be written. Attach a copy of the BIP.**
  - **Provide a statement reviewing communication with other service providers and parents.**
  - **If extended year services are requested, attach data and evidence of regression using the suggested county regression tool or a similar tool.**
- **Summary**
  - **Based on summary of child's assessments, current level of functioning and observations, write a statement that sums up child's strengths and continuing needs or concerns.**
  - ***<u>Service type, frequency, duration and location are determined by the CPSE and must not be included in the report</u>.***
- **Reports must be signed by the classroom teacher and dated.**

NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program

ANNUAL REVIEW PROGRESS REPORT
SEIT SERVICE
GUIDANCE

Name of Student:	Student's Date of Birth:
Date of Report:	Chronological Age:
SEIT Provider Name:	Agency/School Name:
School District:	IEP Dates of Service:

Assessments Administered (Formal/Informal): Assessment Scores/Results:*

1. **List of observation and assessment tools.**
2. **Completed by SEIT during a scheduled session.**

Date of Assessment Type of Assessment

_____ _____

_____ _____

***Current level of functioning: Must include objective data (Could be Age equivalent score, percentile score or standard deviations)**

Summary of Assessment Results and Progress toward Goals(s) and Objective(s):

1. **Include a narrative statement discussing the child's current level of functioning in all areas of development (5 domains) including strengths, continuing needs, and progress achieved.**
2. **Include a narrative statement describing the child's functioning in the environment where the child is seen (at home or the preschool) with his/her typical peers, if applicable.**
3. **Include a narrative statement describing communication with the classroom teacher and parents.**
4. **Include a narrative statement describing the interventions implemented in the classroom.**
5. **If there any are behavioral issues and a BIP is in place, a narrative statement describing the child's response to the BIP must be written. Attach a copy of the BIP.**
6. **Describe progress toward goals (factors influencing child's progress including attendance, parent involvement, classroom teacher involvement)**
7. **Describe progress toward objectives (benchmarks) – those that have been met and those that are still being worked on.**
8. **If you are the Coordinator of Services, provide a statement reviewing your communication and activities with all other service providers and parents.**
9. **If there is evidence concerning a child's regression, describe the regression and provide data.**

Conclusions and Recommendations:

1. **List all other services received by child and family.**
2. **Based on summary of child's assessments, current level of functioning and observations, write a statement that sums up child's strengths and continuing needs or concerns.**
3. **Service type, frequency, duration and location are determined by the CPSE, and therefore, should not be included in the report.**
4. **Recommendations for any additional evaluations must be discussed with your supervisor and then with the CPSE Chair prior to the Annual Review Meeting. The CPSE Chair may require a separate written rationale.**
5. **Any discussion about a child must involve the parent or guardian.**

Signature of SEIT Provider Date

CC: Student's CPSE Chairperson
Parents/Guardians
PS 4003G Guidance SEIT Service Annual Review April 2015

Parent/Caregiver –
DO NOT SIGN BLANK LOG NOTES

NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program

TREATMENT LOG - SEIT

Print legibly/use black ink only
ONE THERAPIST PER LOG

Child's Name (Last, First) DOB: C		Agency/Center-Based School/Independent Contractor D	School District E
Location (Office/Child Care Center/Home/etc) as indicated on IEP F	Town of Service G	Name of Individual Service Provider/ Professional Credentials/ Certificate # (Print) H	
	Type of Service **SEIT**	Frequency & Duration as indicated on the IEP - *Individual* Sessions Per Week: I Minutes:	Frequency & Duration as indicated on the IEP - *Group* Sessions Per Week: J Minutes:
Dates of Service (IEP Dates) K to	☐ Individual ☐ Group L	Frequency & Duration as indicated of this provider– *Individual* Sessions Per Week: M Minutes:	Frequency & Duration as indicated of this provider -*Group* Sessions Per Week: N Minutes:

Location of SEIT services must match location indicated in the student's IEP.

NOTE: All sessions must be signed off by Parent or Authorized Verifying Witness, and the SEIT Provider O

SESSION CODES: P-Service MU – Make Up Session CA – Child Absent
TA- Teacher/Therapist Absent S-CPSE Meeting

Date of Session P	Start Time Q AM PM	End Time R AM PM	Session Code S	Session Notes: Activity related to IEP Goals (Including objectives and measures of success) and response(T	Location of service: U

V _____
* Signature of Parent or Verifying Witness Date

W _____
Provider Signature Date

A Page number
B Total pages submitted for billing cycle for this student and provider
C Child's name and date of birth as written on IEP
D Name of the agency, center-based school or independent contractor who holds the contract for this service as written on the IEP
E Name of the school district as written on the IEP
F Location where the service is provided as written on the IEP
G The name of the town where the service is provided
H The name of the person providing service and his/her professional credentials and certificate number. If certificate number is your social security number, use the last 4 digits.
I Frequency and duration of the individual service as stated on the IEP. For sessions, put the total number of times the service will be given in one week. For minutes, put the total number of minutes per session. If no individual services are approved, indicate NA.
J Frequency and duration of the group service as stated on the IEP. For sessions, put the total number of times the service will be given in one week. For minutes, put the total number of minutes per session. If no group services are approved, indicate NA.
K Dates of service as written on the IEP
L Check off all that apply. If child is receiving both individual and group services, place a check in both boxes.
M Frequency and duration of the individual service for *this provider*. Please complete even if there is only one provider. For sessions, put the total number of times the service will be given in one week. For minutes, put the total number of minutes per session. If no individual services are approved, indicate NA.
N Frequency and duration of the group service for *this provider*. Please complete even if there is only one provider. For sessions, put the total number of times the service will be given in one week. For minutes, put the total number of minutes per session. If no group services are approved, indicate NA.
O DOH requires the completion of form PS 1200 Parent/Guardian Consent for Alternate Signature Verification Form listing the names of the Parent and/or Authorized Verifying Witness when services are provided in the home, nursery school, child care site and there may be someone other than the parent signing the Treatment Log.
P Date of actual session. Must be filled in even if the session is cancelled. In Session Notes, indicate session was cancelled and reason for cancellation.
Q,R Fill in start and end times of each session and circle AM or PM.

S Attendance code as listed in the Session Code box on the Treatment Log.

T Session Notes must include description of activities related to IEP Goals, including objectives, measures of success and child's response to activities.

- Use objective language. Avoid using phrases such as "had a good session."
- Be descriptive and focus on the major activities/lessons, include a brief description of student's progress made during each session.
- Describe child's attending behavior, participation and/or responses to lessons/materials presented.
- Do not use "same as above."
- SEITs should follow the calendar specified on the IEP. If no calendar is indicated, please check with the school district for the calendar to be followed. Indicate in the session box, the date span the service is not provided due to the calendar. No signatures are needed if the school is closed.
- If the session is a make-up session, note the date of the original missed session.

U Location where this session occurred. Location must match what is written on the IEP.

V Signature of Parent/Authorized Verifying Witness, *which must be completed at end of session*. Signature must be dated. If session is cancelled, Parent/Authorized Verifying Witness would sign at the next session using the date when signed.

***** *Nassau County form PS1200 Parent/Guardian Consent for Alternate Signature Verification must be completed.*

W Signature of provider and date must be completed at end of every session.

Student's Name (Last, First): _____X_____ **Page** _Y_ **of** _Z__

Contact and Comments Codes: TC – Telephone Conference CN – Communication Notebook CO -- Coordination
R – Weekly Recommendations/Interventions for Classroom Teacher/Caregiver O – Other

Date	Codes	Notes
AA		

I certify all information entered on this Treatment Log is correct (Provider Sig.)
__BB_____ **Date**
_CC_____/_____/_____

Treatment Log Reviewed by
__DD_____
Date _____EE____/_____/_____

Print Reviewer's Name:
_____FF_____

PS 1100 **SEIT** Treatment Log August 2010

X Child's name as written on the IEP.
Y Page number
Z Total pages submitted for billing cycle for this student and provider
AA Contacts and Comments section must be completed to document communications with parents and other service providers including classroom teachers if applicable. Each entry which must be dated and coded using the Contact and Comment Codes listed, requires a comment/note at a minimum of one per week.
BB Provider's signature
CC Date Treatment Log is submitted
DD Treatment Log must be reviewed and signed by a person designated by the service provider, school or agency to include but not limited to:

- Supervisor or person directly responsible for the provider
- Quality Assurance Officer

- Compliance Officer
- CEO or COO
- Agency designee

This person is responsible for reviewing the completeness, accuracy and quality of the submitted Treatment Log. *Not applicable to independent contractors who have a separate contract with Nassau County*

EE Date Treatment Log was reviewed

FF Print name of person reviewing Treatment Log

PS 1100G SEIT Treatment Log Guidance Document June 2016

Parent/Caregiver –
DO NOT SIGN BLANK LOG NOTES

NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program

Print legibly/use black ink only
ONE THERAPIST PER LOG

TREATMENT LOG - RELATED SERVICES

Child's Name (Last, First) DOB: C			Agency/Center-Based School/Independent Contractor D	NPI # E / School District F
Location of Service as per IEP: (Use code) O=Office, H=Home, PS=Preschool, D=Daycare, CB=Center, X=Other specify _____G___			Print Name of Individual Service Provider/License Number/ASHA #--if applicable H	
Type of Service: I	Dates of Service (IEP Dates) J to		Print Name of Individual Supervising Provider/Professional Credentials/License Number/ NPI #/ASHA# --if applicable K	
RX or Recommendation Date L	ICD10 Code M	☐ Individual ☐ Group Size Per IEP_____ ☐integrated R setting	Frequency & Duration as indicated on the IEP - *Individual* Sessions Per week: N Minutes:	Frequency & Duration as indicated on the IEP – *Group* Sessions Per week: O Minutes:
Town of Service P	NCDOH NPI # 1558403824 Q		Frequency & Duration as indicated for this provider -*Individual* Sessions Per Week: S Minutes:	Frequency & Duration as indicated for this provider--*Group* Sessions Per Week: T Minutes:
** Only NON CB services require a verifying witness signature*			NPI # (Actual Therapist): U	
NOTE: All sessions must be signed off by Parent or Authorized Verifying Witness, Provider and UDO/USO Supervisor for TSHH, TSSLD, CFY, COTA, PTA, LPN or Supervisor of LMSW CC			SESSION CODES: P-Service MU – Make Up Session CA – Child Absent TA - Therapist Absent S - CPSE Meeting	

Date of Session V	Start Time W AM PM	End Time X AM PM	Session Code Y # in Group ___Z___

GG

* Signature of Parent or Verifying Witness Date

HH

Provider Signature Professional Credentials Date

II

USO/UDO Supervisor Signature Professional Credentials Date

Session Notes: Activity related to IEP Goals (Including objectives and measures of success) and respon child

BB

PROGRESS (CHECK ONE): ☐ Progress ☐ Limited Progress ☐ No Progress

CPT Code(s): CC

Location Code DD

Service Type EE

☐ Individua
☐ Group Siz
Per IEP _FF_

A Page number

B Total pages submitted for billing cycle for this student and provider

C Child's name and date of birth as written on IEP

D Name of the agency, center-based school or independent contractor who holds the contract for this service as written on the IEP

E Agency's NPI#

F Name of the school district as written on the IEP

G Location where the service is provided as written on the IEP. Use codes provided.

H The name of the person providing service and his/her license number and ASHA # if applicable (ASHA # for speech language pathologists only). One therapist per log.

I Type of service (speech, OT, PT, etc.) as written on the IEP

J Dates of service as written on the IEP

K Name of person providing supervision [Under the Direction of (UDO) or Under the Supervision of (USO)] for CFY, TSHH, TSSLD, COTA, PTA, LPN, LMSW

L Date the prescription (Rx) or recommendation was signed. If the service (parent training) does not require a prescription or recommendation, put NA in the box.

M ICD10 code is required as of 10/1/2015

N Frequency and duration of the individual service as stated on the IEP. For sessions, put the total number of times the service will be given in one week. For minutes, put the total number of minutes per session. If no individual services are approved, indicate NA.

O Frequency and duration of the group service as stated on the IEP. For sessions, put the total number of times the service will be given in one week. For minutes, put the total number of minutes per session. If no group services are approved, indicate NA

P The name of the town where the service is provided

Q Nassau County's NPI #. Do not change. This NPI# is for all Nassau County Children receiving related services.

R Check if an individual or group service. If group service, write the # of children in the group as specified on the IEP. In addition, check if child in integrated setting.

S Frequency and duration of the individual service for *this provider*. Please complete even if there is only one provider. For sessions, put the total number of times the service will be given in one week. For minutes, put the total number of minutes per session. If no individual services are approved, indicate NA.

T Frequency and duration of the group service for *this provider*. Please complete even if there is only one provider. For sessions, put the total number of times the service will be given in one week. For minutes, put the total number of minutes per session. If no group services are approved, indicate NA.

U NPI # for individual therapist (Speech Language Therapist, OT, PT, LCSW, LMSW, licensed Clinical Psychologist)

V Date of actual session. Must be filled in even if the session is cancelled. In Session Notes, indicate session was cancelled and reason for cancellation.

W,X Fill in start and end times of each session and circle AM or PM

Y,Z Attendance code as listed in the Session Code box on the Treatment Log. If the child is receiving group services, indicate the number of children present at the current session in the space provided.

AA intentionally omitted

BB Session Notes must include description of activities related to IEP Goals, including objectives, measures of success and child's response to activities.

- Use objective language. Avoid using phrases such as "had a good session."
- Be descriptive and focus on the major activities/lessons, include a brief description of student's progress made during each session.
- Describe child's attending behavior, participation and/or responses to lessons/materials presented.
- Do not use "same as above."
- Therapists should follow the calendar specified on the IEP. If no calendar is indicated, please check with the school district for the calendar to be followed. Indicate in the session box, the date span the service is not provided due to the calendar. No signatures are needed if the school is closed.
- If the session is a make-up session, note the date of the original missed session.
- Check one of the boxes indicating child's progress during the session

CC Each session must have appropriate CPT codes that indicate the purpose of the session, whether it was individual or group. Only CPT codes from the approved list from OMIG can be used. If the therapist/agency feels that there is a code that needs to be added to the OMIG list, the desired code and reason for inclusion must be emailed to the Medicaid-in-Education Unit and NYS will make the decision whether or not to add the CPT codes to the list.

DD Fill in a location code for each session. See G.

EE Type of service (speech, OT, PT, etc.) as written on the IEP.

FF Check off whether it is an individual or group service. If the child is receiving group services, write the number of children in the group that were present for the day's session.

GG DOH requires the completion of form PS 1200 Parent/Guardian Consent for Alternate Signature Verification Form listing the names of the Parent and/or Authorized Verifying Witness when services are provided in the home, nursery school, child care site and there may be someone other than the parent signing the Treatment Log. Signature of Parent/Authorized Verifying Witness, *which must be completed at end of session*. Signature must be dated. If session is cancelled, Parent/Authorized Verifying Witness would sign at the next session using the date when signed. Provider must document reason for absence in session note.

HH Signature of provider, professional credentials and date must be completed at end of every session.

II Signature of supervisor is needed when the provider is a TSHH, TSSLD, CFY, COTA, PTA, LPN or LMSW.

Student's Name (Last, First)

Contact and Comments Codes: TC – Telephone Conf CN – Communication Notebook CO – Coordination R – Wkly Recommendations/Interventions for Classroom Teacher/Caregiver O – Other		
Date	**Codes**	**Notes**
MM		

: _____JJ_____ Page _KK__ of __LL_

I certify all information entered on this Treatment Log is correct (Provider Sig.) _____NN_____ **Date**_____/_____/_____

Treatment Log Reviewed by _____OO_____ **Date**___ _____/_____/_____

Print Reviewer's Name: _____PP_____

PS 1100 RS Treatment Log revised 08/09/2011

JJ **Child's name as written on the IEP**

KK **Page number**

LL **Total pages submitted for billing cycle for this student and provider**

MM **Contacts and Comments section must be completed to document communications with parents and other service providers including classroom teachers if applicable. Each entry which must be dated and coded using the Contact and Comment Codes listed, requires a comment/note at a minimum of one per week.**

NN **Provider's signature and date,**

OO **Treatment Log must be reviewed, signed and dated by a person designated by the service provider, school or agency to include but not limited to:**

- **Supervisor or person directly responsible for the provider**
- **Quality Assurance Officer**
- **Compliance Officer**
- **CEO or COO**
- **Agency designee**

This person is responsible for reviewing the completeness, accuracy and quality of the submitted Treatment Log. ***Not applicable to independent contractors who have a separate contract with Nassau County.***

PP **Print name of person reviewing Treatment Log.**

APPENDIX V

( ) Original
( ) Amendment ___/___/___
( ) Rescind ___/___/___

Nassau County Department of Health
Office of Children with Special Needs
PRESCHOOL BUS
TRANSPORTATION REQUEST FORM (TRF)

Upload one TRF per school session

School District Name: _____

Section I

Child's Legal Last Name _____ First _____ M.I. ____ DOB___/___/___ M ___ F ___

Legal Address _____ Town _____ Zip Code _____

Parent/Guardian _____ Cell ( ) _____ Additional Phone ( ) _____
or Foster Parent
Parent Name

_____ Cell ( ) _____ Additional Phone ( ) _____
Partner/Spouse Name

Provider: _____

Street Address: _____ Town: _____

Start Time: _____ End Time: _____ Start Date ___/___/___ End Date ___/___/___

Section II – Routing - The bus will pick up and drop off this child from the legal address listed above unless a different location is requested below

PICK UP: Other Address M T W TH F Other Address M T W TH F
Circle Days Circle Days

BASED ON THE ROUTE AND/OR THE LOCATION OF PROVIDER SCHOOL, ROUTES CAN BE 90 MINUTES ONE WAY

PICK UP – IF OTHER THAN LEGAL ADDRESS	DROP-OFF – IF OTHER THAN LEGAL ADDRESS
Authorized Person:	Authorized Person:
Address:	Address:
City:	City:
Phone: Cell:	Phone: Cell:

Section III – Additional Authorized Persons

PERSONS AUTHORIZED TO RECEIVE CHILD: (MUST SHOW ID)	
NAME:	RELATIONSHIP:
NAME:	RELATIONSHIP:
NAME:	RELATIONSHIP:

Section IV – Seating and Special Needs* (Must check either Safety Restraint and supply child's weight OR Wheelchair***)**

Seating: [ ] **Safety Restraint** **Child's Weight** _____
[ ] Wheel Chair *_____ Manual*_____ or Electric*_____ Adaptive Stroller*_____ **Lift Bus Must be authorized on IEP**
[ ] Medical Needs or Other Concerns:_____
[ ] **Health Care Professional must be authorized on the child's IEP to accompany child on the bus. Check only one:** ( ) LPN ( ) RN
*ALL MOBILITY DEVICES MUST BE APPROVED BEFORE TRANSPORTATION CAN BEGIN

Section V - LOCAL EMERGENCY DROP OFF

(Must list two in Nassau County, in close proximity of school or home)

EMERGENCY DROP OFF # 1	EMERGENCY DROP OFF # 2
Name:	Name:
Relationship:	Relationship:
Address:	Address:
City: Nassau County, NY Zip:	City: Nassau County, NY Zip:
Phone: Cell:	Phone: Cell:

Section VI – Parent Transporting:

[ ] **Reimbursement** [ ] **No Reimbursement**
Circle which way the Parent/Guardian is driving: Driving child to school: M T W TH F Driving child home from school: M T W TH F

Section VII – Authorizing Signatures

Review all information before signing

_____/____/____ and/or _____/____/____
SIGNATURE OF SCHOOL REPRESENTATIVE DATE PARENT/GUARDIAN/SURROGATE SIGNATURE DATE

TRF December 2021

[ ] Original
[ ] Modificación ___/___/___
[ ] Rescind ___/___/__

Oficina de Servicios para Niños con Necesidades Especiales
del Departamento de Salud del Condado de Nassau
AUTOBÚS PREESCOLAR
FORMULARIO DE SOLICITUD DE TRANSPORTE (TRF)

Cargar un TRF por cada sesión escolar

Nombre del distrito escolar: _____

Sección I
Apellido legal del niño _____ Nombre _____ Inicial del2. nombre. _____ Fecha de nac. ____/___/____ M___ F___

Dirección legal _____ Ciudad _____ Código postal _____

Padre/madre/tutor legal _____ Teléfono celular ( ) _____ Otro Teléfono ( ) _____
o Padre de cuidado temporal Nombre

_____ Teléfono celular ( ) _____ Otro Teléfono ( ) _____
Nombre del cónyuge

Proveedor _____
Dirección: _____
Horarios de inicio: _____ Hora de finalización:_____ Fecha de inicio ___/___/___ Fecha de finalización ___/___/___

Sección II: Recorrido (El autobús recogerá y dejará al menor en la dirección legal indicada arriba, a menos que se indique un lugar diferente aquí abajo).

RECOIDA: [ ] Otra dirección Lu. Ma. Mi. Ju. Vi. [ ] Otra dirección Lu. Ma. Mi. Ju. Vi.
Marcar los días con un círculo Marcar los días con un círculo

SEGÚN EL RECORRIDO O LA UBICACIÓN DE LA ESCUELA DEL PROVEEDOR, LOS RECORRIDOS PUEDEN TENER UNA DURACIÓN DE 90 MINUTOS POR TRAMO.VÍA	
RECOGIDA (SI EL LUGAR ES DISTINTO A LA DIRECCIÓN LEGAL)	**RECIBIMIENTO (SI EL LUGAR ES DISTINTO A LA DIRECCIÓN LEGAL)**
Persona autorizada:	Persona autorizada:
Dirección:	Dirección:
Ciudad:	Ciudad:
Teléfono: _____ Tel. celular: _____	Teléfono: _____ Tel. celular: _____

Sección III: Otras personas autorizadas

PERSONAS AUTORIZADAS PARA RECIBIR AL MENOR: (DEBERÁN MOSTRAR UNA IDENTIFICACIÓN)	
NOMBRE:	RELACIÓN:
NOMBRE:	RELACIÓN:
NOMBRE:	RELACIÓN:

Sección IV: Adaptación del asiento y necesidades especiales* (Se debe marcar la opción "Sistema de sujeción" e indicar el peso del menor O la opción "Silla de ruedas:"***).**

Asiento: *****[ ] Sistema de sujeción Peso del menor _____
Asiento: *****[ ] Silla de ruedas _____Manual_____ o Eléctrica _____ Silla adaptable _____ El autobús con elevador debe autorizarse en el IEP
[ ] Necesidades médicas u otras inquietudes:_____
[ ] El profesional de atención médica debe estar autorizado en el IEP del menor para poder acompañar al menor en el autobús.
Marcar solo una opción: ( ) LPN ( ) RN
*TODOS LOS DISPOSITIVOS DE MOVILIDAD DEBEN APROBARSE ANTES DE QUE SE PUEDA INICIAR EL TRANSPORTE.

Sección V: LUGAR DE RECIBIMIENTO DE EMERGENCIA LOCAL

(Se deben indicar dos lugares dentro del condado de Nassau cercanos a la escuela o a la casa).	
LUGAR DE RECIBIMIENTO DE EMERGENCIA 1	**LUGAR DE RECIBIMIENTO DE EMERGENCIA 2**
Nombre:	Nombre:
Relación:	Relación:
Dirección:	Dirección:
Ciudad: Condado de Nassau, NY Código postal:	Ciudad: Condado de Nassau, NY Código postal:
Teléfono: _____ Tel. celular: _____	Teléfono: _____ Tel. celular: _____

Sección VI: Transporte a cargo del padre/de la madre:

[ ] Con reembolso [ ] Sin reembolso
Marcar con un círculo el tramo del que se encarga el padre, la madre o el tutor legal: De la casa a la escuela: Lu. Ma. Mi. Ju. Vi. De la escuela a la casa: Lu. Ma. Mi. Ju. Vi.

Sección VII: Firmas de autorización

Antes de firmar revise toda la información.

_____/____/____ y _____/____/____
FIRMA DEL REPRESENTANTE ESCOLAR FECHA FIRMA DEL PADRE, DE LA MADRE O DEL LEGAL/ PADRE O MADRE DE CUIDADO TEMPORAL TUTOR FECHA

TRF 04/2019 revisado

APPENDIX W

District Name:

Upload one form for Summer and one form for Fall

Amendment Date ___/___/ ____

NASSAU COUNTY DEPARTMENT OF HEALTH
PRESCHOOL SPECIAL EDUCATION

CENTER BASED AND TRANSPORTATION OPTIONS NOTIFICATION FORM

1) Transportation Option – must indicate an option:
In accordance with: The University of the State of New York, THE STATE EDUCATION DEPARTMENT, Office of P-12 Education Office of Special Education's REGULATIONS OF THE COMMISSIONER OF EDUCATION, Pursuant to Sections 207, 3214, 4403, 4404 and 4410 of the Education Law 4410 (8), PART 200 Students with Disabilities Section 200.16 (e) (5):

In developing its recommendation for a preschool student with a disability to receive programs and services, the committee must identify transportation options for the student and request and encourage parents to transport their child at public expense where cost-effective.

Please check one of the following transportation options determined by the Board of Education based on the recommendation of the Committee on Preschool Special Education (CPSE), which was made with your participation:

__ A) I choose to be reimbursed at public expense at the Federal rate to transport my child to and from the approved preschool special education program selected by the Board of Education of the school district where my child resides. Note: Mileage Reimbursement must be indicated on the IEP and retroactive Mileage Reimbursement requests cannot be honored.

Required information: **____ Driving Round Trip** or **____ Driving One-way (___ to school or ___ to home)**

_____ _____ _____
Print Name of parent/guardian to appear on reimbursement check. ***SSN or TIN of parent/guardian receiving reimbursement check.*** ***Date***

__ B) I choose to transport my child **Round Trip_____ or ____ Driving One-way (___ to school or ___ to home)** the approved preschool special education program selected by the Board of Education of the school district where my child resides and **I do not want reimbursement** at public expense.

__ C) **____ Bus One-way (___ to school only or ___ to home only) or ____ Bus Round Trip**
The Nassau County Department of Health Preschool Special Education Program requests the parent/guardian to **indicate an inability or declination to transport their child** to and from the child's preschool special education program. A TRF will be submitted by the school district to the transportation management company on my child's behalf.

I, the parent/guardian/surrogate of the above-named child, request bus transportation of my child to and from the center based services to be provided at public expense from Nassau County funds pursuant to section 4410 of the New York State Education Law. **I am unable and decline to transport my child to his/her preschool special education program. I choose the municipality to provide suitable transportation at public expense for my child, as determined by the Board of Education of the school district where my child resides. I am aware and accept that the bus ride could take 90 minutes each way.**

_____ _____
Parent/Legal Guardian's signature* ** **Date**

***Annual Review transportation option can be confirmed by CPSE Chair when parent/legal guardian does not attend CPSE meeting. CPSE Chair completes section 1 and signs this document in place of parent/legal guardian.

2) Transfer Student Information:

Transfer Student from: _____ Birth Certificate required

3) Child Demographics:

CHILD'S LEGAL NAME:		M:	F:	DOB:
ADDRESS:	TOWN:	*(Must Include) ZIP:*		
PARENT/GUARDIAN NAME:		PHONE:		
Foster Placement: Y / N	County at Time of Foster Care Placement from LDSS 2999:	Agency Name from LDSS 2999:		
Agency Address from LDSS 2999:		Agency Phone from LDSS 2999:		

District Name

Cargar un TRF por cada sesión escolar
Amendment Date __/___/ __

DEPARTAMENTO DE SALUD DEL CONDADO DE NASSAU
CENTRO DE EDUCACIÓN ESPECIAL PREESCOLAR BASADO Y FORMULARIO DE NOTIFICACIÓN DE OPCIONES DE TRANSPORTE

1) La opción de transporte, debe indicar una opción:

De acuerdo con: La Universidad del Estado de Nueva York, EL DEPARTAMENTO DE EDUCACIÓN DEL ESTADO, REGULACIONES DEL COMISIONADO DE EDUCACIÓN DE Oficina de educación P-12 Oficina de Educación especial , de acuerdo con los Artículos 207, 3214, 4403, 4404 y 4410 de la Ley de educación 4410 (8), PARTE 200 Estudiantes con discapacidades Sección 200.16 (e) (5):

Al desarrollar su recomendación para un estudiante preescolar con una discapacidad para recibir los programas y servicios, el comité debe identificar las opciones de transporte para el estudiante y solicitar y exhortar a los padres a que transporten a su hijo en el transporte público cuando sea a un precio módico.

Marque una opción de las siguientes opciones de transporte como lo determina la Junta de Educación con base en la recomendación del Comité sobre Educación especial preescolar (Committee on Preschool Special Education, CPSE), lo cual se hizo con su participación:

___ A) Yo elijo que se me reembolse del gasto público la tarifa federal para transportar a mi hijo hacia y desde el programa de educación especial preescolar aprobado seleccionado por la Junta de educación del distrito escolar donde reside mi hijo.

Información requerida: **____ Conducir en el viaje ida y vuelta o ____ Conducir en viaje de una vía (___ hacia la escuela o ___ hacia la casa)**

_____ _____
Nombre en letra de molde del padre/tutor legal como aparecerá en el cheque de reembolso. *SSN o TIN del padre/tutor legal que recibe el cheque de reembolso.*

___ B) Yo elijo transportar a mi hijo hacia y desde el programa de educación especial preescolar aprobado por la Junta de educación del distrito escolar donde reside mi hijo y **No quiero un reembolso** del gasto público.

__ C) **____ Autobús una vía (___ solo hacia la escuela o ___ solo hacia la casa) o ____ Bus ida y vuelta**
El Programa de educación especial preescolar del Departamento de Salud del Condado de Nassau solicita que el padre/tutor legal **indique la incapacidad o declinación para transportar a su hijo** hacia y desde el programa de educación especial preescolar del niño. El distrito escolar enviará TRF a la compañía de administración de transporte en nombre de mi hijo.

Yo, el padre/tutor legal/sustituto del niño mencionado antes, solicito transporte en autobús para mi hijo hacia y desde los servicios en el centro para que sea proporcionado del gasto público de los fondos del condado de Nassau de acuerdo al artículo 4410 de la Ley de Educación del estado de Nueva York. **No puedo y declino transportar a mi hijo hacia su programa de educación especial. Elijo que la municipalidad proporcione transporte adecuado del gasto público para mi hijo, según lo determina la Junta de educación del distrito escolar donde reside mi hijo.**

_____ _____
Firma del padre/tutor legal* (Requerido para todas las opciones)** **Fecha**

***La opción de transporte de revisión anual la puede confirmar el Encargado de CPSE cuando el padre/tutor legal no asiste a la reunión de CPSE. El Encargado de CPSE completa la sección 1 y firma el documento en lugar del padre/tutor legal.

2) Datos demográficos del niño: ***Transferir al estudiante desde:*** _____ **EVAL CPSE FUERA DEL CONDADO: S / N**
INICIALES: S / N (Encierre una opción en un círculo. Se necesita certificado de nacimiento con los envíos iniciales)

NOMBRE LEGAL DEL NIÑO:		M:	F:	Fecha de nacimiento:
DIRECCIÓN:	CIUDAD:	*(Debe incluir el código postal):*		
NOMBRE DEL PADRE/TUTOR LEGAL:		TELÉFONO:		
Colocación en cuidado temporal: S / N	Condado en el momento del cuidado temporal Colocación de LDSS 2999 :	Nombre de la agencia de LDSS 2999:		
Dirección de la agencia de LDSS 2999:		Teléfono de la agencia de LDSS 2999:		

3) ¿Su hijo ha sido diagnosticado con el Trastorno del espectro autista (Autism Spectrum Disorder, ASD)?
Debe encerrar una opción en un círculo: ASD SÍ / NO

4) Clave del código del programa BASADO EN EL CENTRO: comuníquese con el proveedor del centro (Los códigos del programa se deben completar en las casillas de la sección 10 de STAC-1. Complete el sufijo Alfa si lo conoce. EL ENCARGADO DEBE DAR LAS FECHAS EXACTAS PARA EL INICIO TARDIO. Recordatorio: los programas en el centro son programas basados en una colegiatura que deben proveer Terapia del habla, Terapia ocupacional y Terapia física como parte de su colegiatura. En el centro *tiempo completo* 1:1 Se indican los asistentes en la sección 10 de STAC-1. Para enfermero o *parcial* 1:1Asistente en el programa basado en el centro, complete la SOLICITUD DE REEMBOLSO DE NYSED PARA AYUDA PARCIAL 1:1 ASISTENTE, 1:1 ENFERMERO, 1:1 INTERPRETE y envíelo con STAC-1.)

(Consulte STAC-1 adjunto)

PS CB2001 revised 02- 2018

APPENDIX X

PROVIDER / DISTRICT

Signature instructions Nassau County Department of Health
Office of Children with Special Needs
Preschool Special Education Program

District: Upload and submit in eSTACs
Provider: Send copy to Swissport & District

Preschool Special Education Transportation Change Request Form

Section I – Child Demographics

Date: _____

Provider Name: _____ **Location:** _____

Child Last Name: _____ **Child First Name:** _____

DOB / / **Gender:** Male Female **School District:**

Section II – Session Time Correction

Original Start Time: _____ Original End Time: _____
New Start Time: _____ **Cannot change from AM to PM or PM to AM** New End Time: _____

Note: Cannot change from half-day to full day or full-day to half-day, must contact the school district CPSE Office.

Section III – Change of Pick-up and/or Drop-off Location

When the home address DOES NOT change

Parent/Guardian must contact the school district CPSE Office when the home address changes/family moved.

Note: Short-term pick-up or drop-off change requests have a negative impact on all children; therefore, the Transportation Providers cannot accommodate these requests.

New Pick-up location Effective Date of Change: _____

Address: _____ City/Town: _____ Zip Code: _____

Phone Number: _____ Authorized Person(s): _____

Mon._____ Tues._____ Wed._____ Thurs. _____ Fri. ._____

New Drop-off Effective Date of Change: _____

Address: _____ City/Town: _____ Zip Code: _____

Phone Number: _____ Authorized Person(s): _____

Mon._____ Tues._____ Wed._____ Thurs. _____ Fri. _____

Section IV – Emergency Drop-Off Information

Authorized Person and Phone contact information must be different from parent/guardian information!

Address: _____ City/Town: _____ Zip Code: _____

Phone Number: _____ Authorized Person(s): _____

Section V – Authorized Persons

Add / Delete: Name: _____ Add / Delete: Name: _____
Add / Delete: Name: _____ Add / Delete: Name: _____

Section VI – Authorizing Signatures – Provider or School District personnel may sign on behalf of the parent/guard.

Parent/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____

District Authorized Signature: _____ Date: _____

CB 2010 June 2022 Provider: Send one copy to Swissport immediately and one copy to the school district
School District: Upload form into eSTACs and submit document

School District Only

Nassau County Department of Health
Office of Children with Special Needs
Preschool Special Education Program

District: Upload and submit in eSTACs

Preschool Special Education Transportation Change Request Form

Section I – Child Demographics

School District: _____

Child Last Name: _____ **Child First Name:** _____

DOB / / **Gender:** Male Female

Provider Name: _____ **Location:** _____

Section II – End Date Change

Reason: ____Child transferred to _____District. Last Day ____/____/____ End placement in eSTACs

____Child no longer attending center-based program as of ____/____/_____ End placement in eSTACs

____Other:_____ of ____/____/_____ End placement in eSTACs

Section III – Transportation Mode Change

Requires Amended IEP, TRF, eSTACs Transportation Details, and CB 2001

A. Parent/Guardian Driving Round Trip start date: ____/____/___

B. Parent/Guardian Driving One-way _____AM or ____PM start date____/____/___ (May need to submit TRF)

C. Round Trip bus transportation start date: ____/____/_____ (Submit TRF in addition to the forms listed above)

D. Wheelchair Start date: ____/____/_____ End Date: ___/___/___

Manual____ or Electric _____ or Adaptive Stroller_____ (Must be on IEP)

Section IV– Transportation Session Time

Original Start Time: _____ Original End Time: _____

New Start Time: _____ New End Time: _____

Amended/Corrected IEP and if necessary, placement submitted in eSTACs on ____/____/_____

Section V– Location Change within same Center Based Program

Requires Amended IEP, new TRF, new CB 2001 and if necessary, new placement. Upload and Submit in eSTACs

Effective Date: ____/____/___

Original location approved on IEP: _____

New location approved on IEP: _____

Section VI– New Center Based Program

Requires the following Uploaded and Submitted in eSTACs:

_____ Amendments to the Original IEP, STAC-1 and, Rescinded TRF

_____ New STAC-1, new CB 2001, new IEP, and new TRF

Please inform the Parent/Guardian these changes can take up to two weeks before the bus can be routed.

Section VII– Change of Pick-up and/or Drop-off

When the home address changes and the school district remains the same.

New Pick-up location Effective Date of Change: _____

Address: _____ City/Town: _____ Zip Code: _____

Phone Number: _____ Authorized Person(s): _____

Mon._____ Tues._____ Wed._____ Thurs. _____ Fri._____

New Drop-off Effective Date of Change: _____

Address: _____ City/Town: _____ Zip Code: _____

Phone Number: _____ Authorized Person(s): _____

Mon._____ Tues._____ Wed._____ Thurs. _____ Fri. _____

Section VIII– Authorizing Signatures

Parent/Guardian Signature: _____ Date: _____

School District Authorized Signature: _____ Date: _____

NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
PRESCHOOL SPECIAL EDUCATION PROGRAM

TRANSPORTATION AND CHANGE OF ADDRESS NOTIFICATION REQUIREMENTS

Child's Name: _____ **Child's Date of Birth:** _____

Address of Child: _____ **Apt/Unit** _____

City: _____ **State:** _____ **Zip code:** _____

Today's date: _____ **School District of Residence:** _____

Center Based Program Provider: _____

In accordance with: The University of the State of New York, THE STATE EDUCATION DEPARTMENT, Office of P-12 Education and Office of Special Education's REGULATIONS OF THE COMMISSIONER OF EDUCATION, Pursuant to Sections 207, 3214, 4403, 4404 and 4410 of the Education Law, PART 200 Students with Disabilities Section 200.16 (e) (5)

In developing its recommendation for a preschool student with a disability to receive programs and services, the committee must identify transportation options for the student and request and encourage parents to transport their child at public expense where cost-effective.

I _____, the parent/guardian/surrogate of the above named child, acknowledge that if my child no longer resides at the above address, I will notify the above named school district. If my child needs to be "picked up" or "dropped off" at a different location than originally agreed to, I will notify the school that my child attends. I will make notifications in writing prior to this change taking effect.

If the address change results in my child becoming a resident of a different school district and/or municipality, and I want my child to continue receiving preschool special education programs and services, I will register my child with the new school district and will refer my child to the CPSE chairperson of the new school district.

If I do not inform the new school district within two weeks of moving, there may be an interruption in busing for my child.

Parent/Legal Guardian's signature: _____

Date: _____

Directions for CPSE Chair:

One copy to parent and retain a copy of this form the child's record so that it is available for inspection upon the request by the Nassau County Department of Health Preschool Special Education Program

APPENDIX Z

Child's Name (Last, First) DOB:	Agency / Center-Based School or Independent Contractor	NPI #	School District
Type of Service (SP/OT/PT/Psych/Nursing/etc.)	Print Name of Individual Service Provider	Frequency	Duration

Date of service	Start time	End time	Session Code:	Parent/Guardian Signature/Verifying Witness Signature

Session Codes: P- Service; MU- Makeup; CA- Child Absent; TA- Therapist/Teacher Absent; S- CPSE meeting

I certify that on the dates above, the above-named child received the services noted and that documentation exists and is maintained on file verifying the delivery of said services in accordance with all relevant federal, state and local laws and regulations governing the Medicaid process.

Therapist Signature_____

Nassau County Department of Health
Preschool Special Education Program

PARENT/GUARDIAN CONSENT FOR ALTERNATE VERIFICATION SIGNATURE

I, _____, parent/guardian of _____ give
(Parent/Guardian's Name Printed)

permission for the following individuals to sign treatment logs on my behalf.

Please list individuals who will be able to sign - Day Care Staff, Teacher, Caregiver, etc. (must be over 18)

Name	Title	Signature

_____ _____
(Parent/ Guardian Signature) (Date of Signature)

I, _____ hereby withdraw the above permission as of _____.
(Print name of Parent/Guardian) (Date of Withdrawal)

_____ _____
(Signature of Parent/Guardian) (Date)