Your District Name Your District Address Your District Address Your District Address	Your CPSE Chair's Name Your District Phone Number w/ext Your District FAX Number Date Sent to NCDOH _________ Initials________	☐10-Month Session 201__ - 201_ ☐ 2-Month Session 201__ ☐ 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.

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.

__ B) I choose 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 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.**

____ _____________

Parent/Legal Guardian's signature* (Required for all options) 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) Child Demographics: ***Transfer Student from:*** ______________________ **CPSE EVAL OUT OF COUNTY: Y / N**

INITIAL: Y / N (Circle one – Birth Certificate required with initial submissions)

CHILDS LEGAL NAME:		M:	F:	DOB:
ADDRESS:	TOWN:	*(Must Include Zip Code) 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:		

3) Has this child been diagnosed with Autism Spectrum Disorder (ASD)? Must circle one: ASD YES / NO

4) CENTER BASE SED Program Code Key: Contact Center Based Provider (Program Codes are to be filled in the boxes in section 10 of the STAC-1. Fill-in Alpha Suffix if known. CHAIR MUST GIVE EXACT DATES FOR LATE STARTS. Reminder: Center Based Programs are tuition based programs that must supply Speech Therapy, Occupational Therapy, and Physical Therapy as part of their tuition rate. Center-Base *full-time* 1:1 Aides are indicated in section 10 of the STAC-1. For nurse or *partial* 1:1Aide in center based program, complete NYSED REQUEST FOR REIMBURSEMENT FOR PARTIAL 1:1 AIDE, 1:1 NURSE, 1:1 INTERPRETER and submit with the STAC-1.)

(See attached STAC-1)