



District Name:
Address:

CPSE Chair:
Phone Number w/ext.:
FAX Number:

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:	