



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

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

## APPLICATION FOR TUITION ASSISTANCE PROGRAM FOR DEAF INFANTS

Infant's Name: \_\_\_\_\_ Sex:  F  
(Last) (First)  M

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

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

### STATEMENT OF PARENT OR LEGAL GUARDIAN

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

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

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

County: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

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

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

List other evaluations that have been done: \_\_\_\_\_

---

---

### SED USE ONLY

Approved

Denied

\_\_\_\_\_  
Signature of Representative

\_\_\_\_\_  
Date