

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
P-12 Education: Office of Special Education
Central Office Administrative Support Services Team
(COASST)
Albany, New York 12234
www.p12.nysed.gov

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Rate Setting Unit
Albany, New York 12234
www.oms.nysed.gov/rsu

Approved School-Age Special Education Extended School Year July/August Special Class Programs

Program Modification Request Form

**[To Request Modifications to Extended School Year July/August
Special Classes Approved Prior to July/August 2011]**

January 2011

Approved School-Age Extended School Year July/August Special Education Special Class Program Modification Requests

- This program modification request is to be used by a school district or private agency which has already been approved by the New York State Education Department (SED) to operate extended school year (ESY) July/August full day (9000) or half-day (9010) special classes under Section 4408 of the Education Law.
- This program modification request must be completed and submitted no later than June 30th of a school year when an agency proposes to take one or more of the following actions:
 - 1) Change the approved student/staff ratio
 - 2) Add an additional student/staff ratio to an existing program
 - 3) Modify the approved age range
 - 4) Add disability classifications
 - 5) Add related and other services
 - 6) Modify the hours of operation
- This program modification form has separate sections for 9000 full day and 9010 half-day programs to allow an agency to modify existing SED-approved full day and half-day programs with the submission of one request form.

Please note: A program modification request is not necessary when an agency plans to operate additional or fewer classes of the currently approved student/staff ratio for ESY July/August programs for a school year.

General Instructions

- All applicants must complete **Section A** and **Section D** of the attached Program Modification Form and B-1/B-2 and/or C-1/C-2, whichever are applicable.
- Program-related questions should be referred to the appropriate Special Education Quality Assurance Regional Office (see page 4).
- Fiscal questions should be referred to the Rate Setting Unit (see page 3).
- Submit the original completed modification request to the Central Office Administrative Support Services Team (COASST) by e-mail (**PREFERABLE METHOD**), FAX or regular mail (see page 3 for e-mail and regular mail addresses and FAX number).
- It is the Department's intent to process program modifications within 30 business days of receipt of a completed modification request.

CENTRAL OFFICE ADMINISTRATIVE SUPPORT SERVICES TEAM (COASST)

Contact Information

- E-mail: lkeech@mail.nysed.gov (preferable method of submission)

- Regular Mail: NYS Education Department

P-12: Office of Special Education

COASST Unit

Attention: 4408 Program Modification Review

89 Washington Avenue

Room 681, Education Building Annex

Albany, NY 12234

- FAX: (518) 486-1027 to the attention of Ms. Linda Keech
- Telephone: (518) 473-6108

**Rate Setting Unit
NYS Education Department
Room 304 EB
Albany, NY 12234
(518) 474-3227
(518) 486-3606 (FAX)**

**P-12: OFFICE OF SPECIAL EDUCATION
SPECIAL EDUCATION QUALITY ASSURANCE (SEQA)**

REGIONAL OFFICES

<p>WESTERN REGIONAL OFFICE (NYS School for the Blind) NYS Education Department P-12: Office of Special Education Special Education Quality Assurance 2A Richmond Avenue Batavia, New York 14020 (585) 344-2002</p> <p>Christopher Suriano, Supervisor</p>	<p>EASTERN REGIONAL OFFICE (One Commerce Plaza) NYS Education Department P-12: Office of Special Education Special Education Quality Assurance Room 1623 – One Commerce Plaza Albany, New York 12234 (518) 486-6366</p> <p>Andrew Jackowski, Supervisor</p>
<p>CENTRAL REGIONAL OFFICE (VR District Office) NYS Education Department P-12: Office of Special Education Special Education Quality Assurance State Tower Building 109 S. Warren Street, Suite 320 Syracuse, NY 13202 (315) 476-5081</p> <p>Suzanne Jackson, Supervisor</p>	<p>LONG ISLAND REGIONAL OFFICE (Western Suffolk BOCES) NYS Education Department P-12: Office of Special Education Special Education Quality Assurance The Kellum Educational Center 887 Kellum Street Lindenhurst, NY 11757 (631) 884-8530</p> <p>Eileen Taylor, Supervisor</p>
<p>NEW YORK CITY REGIONAL OFFICE</p> <p>NYS Education Department P-12: Office of Special Education Special Education Quality Assurance 55 Hanson Place Room 545 Brooklyn, NY 11217-1580 (718) 722-4544</p> <p>Belinda Johnson, Supervisor Kathy Cummings, Supervisor Richard Governale, Supervisor</p>	<p>HUDSON VALLEY REGIONAL OFFICE</p> <p>(Putnam/N. Westchester BOCES) NYS Education Department P-12: Office of Special Education Special Education Quality Assurance 1950 Edgewater Street Yorktown Heights, NY 10598 (914) 245-0010</p> <p>Christine Efner, Supervisor</p>
<p>NONDISTRICT UNIT (One Commerce Plaza) NYS Education Department P-12: Office of Special Education Special Education Quality Assurance Room 1623 – One Commerce Plaza Albany, New York 12234 (518) 473-1185</p> <p>Eileen Borden, Supervisor</p>	

Extended School Year July/August Special Class

Program Modification Request

Section A: General Agency/District Information

1. Legal Name of Agency/District	
2. Doing Business As (DBA), if applicable	
3. Mailing Address of Agency, School or District Administrative Office	Street
	City State Zip
4. Address of Program Site(s), if different (attach addresses of other sites, if applicable)	Street
	City State Zip
5. County and School District where Administrative Office is Headquartered	County
	School District
6. Contact Person	7. Agency/District 12-digit SED Code (required)
8. Telephone/E-mail Address	9. Fax Number
Area Code _____ Number _____ Ext. _____	Area Code _____ Number _____
E-mail Address: _____	

Section B-1: Full Day Special Class (9000) – Current Program Model

Directions: Complete the information below indicating the **currently approved** extended school year July/August full day (9000) special class program model:

1) Check each SED-approved staffing ratio and indicate the number of classes of each:

Staffing Ratio	<input type="checkbox"/> 15:1	<input type="checkbox"/> 12:1 ¹	<input type="checkbox"/> 12:1+1	<input type="checkbox"/> 6:1+1	<input type="checkbox"/> 8:1+1	<input type="checkbox"/> 12:1+ (3:1)	<input type="checkbox"/> Other:
Number of Classes at Each Staffing Ratio							

2) Age (range) of student(s): _____ to _____

¹ State-operated or State-supported schools only

3) Check each disability the agency is currently approved to serve:

<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Multiple Disabilities	<input type="checkbox"/> Autism
<input type="checkbox"/> Emotional Disturbance	<input type="checkbox"/> Visual Impairment (including Blindness)	<input type="checkbox"/> Speech or Language Impairment	
<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Deaf-Blindness	<input type="checkbox"/> Other Health-Impairment	
<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Deafness	<input type="checkbox"/> Orthopedic Impairment	

4) Check each Related Service and write in Other Services currently approved by SED for this program:

<input type="checkbox"/> Speech/Language Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Psychological Services
<input type="checkbox"/> School Social Work	<input type="checkbox"/> Counseling	<input type="checkbox"/> Vision Services
<input type="checkbox"/> Audiology Services	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

5) Number of hours of **daily instruction excluding** the lunch period: _____.

Section B-2: Full-Day Special Class (9000) – Proposed Modification(s)

Directions: Complete the information below indicating the **proposed modification(s)** the agency is requesting for its existing extended school year July/August full-day (9000) special class program model:

1) Complete the chart below with the proposed staffing ratio and indicate the number of classes of each, **including any approved classes the agency proposes to continue operating in addition to requesting (a) new staff/student ratio class/classes:**

Staffing Ratio	<input type="checkbox"/> 15:1	<input type="checkbox"/> 12:1 ²	<input type="checkbox"/> 12:1+1	<input type="checkbox"/> 6:1+1	<input type="checkbox"/> 8:1+1	<input type="checkbox"/> 12:1+ (3:1)	<input type="checkbox"/> Other:
Number of Classes at Each Staffing Ratio							

2) Proposed Age (range) of student(s): _____ to _____

3) Check each disability the agency proposes to add to its existing program model:

<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Multiple Disabilities	<input type="checkbox"/> Autism
<input type="checkbox"/> Emotional Disturbance	<input type="checkbox"/> Visual Impairment (including Blindness)	<input type="checkbox"/> Speech or Language Impairment	
<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Deaf-Blindness	<input type="checkbox"/> Other Health-Impairment	
<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Deafness	<input type="checkbox"/> Orthopedic Impairment	

² State-operated or State-supported schools only

4) Check each Related/Other Service the agency proposes to add to the existing program:

<input type="checkbox"/> Speech/Language Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Psychological Services
<input type="checkbox"/> School Social Work	<input type="checkbox"/> Counseling	<input type="checkbox"/> Vision Services
<input type="checkbox"/> Audiology Services	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

5) Proposed revised number of hours of **daily instruction**: _____

Section C-1: Half-Day Special Class (9010) – Current Program Model

Directions: Complete the information below indicating the currently approved extended school year July/August half-day (9010) special class program model:

1) Check each SED-approved staffing ratio and indicate the number of classes of each:

Staffing Ratio	<input type="checkbox"/> 15:1	<input type="checkbox"/> 12:1 ³	<input type="checkbox"/> 12:1+1	<input type="checkbox"/> 6:1+1	<input type="checkbox"/> 8:1+1	<input type="checkbox"/> 12:1+ (3:1)	<input type="checkbox"/> Other:
Number of Classes at Each Staffing Ratio							

2) Age (range) of student(s): _____ to _____

3) Check each disability the agency is currently approved to serve:

<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Multiple Disabilities	<input type="checkbox"/> Autism
<input type="checkbox"/> Emotional Disturbance	<input type="checkbox"/> Visual Impairment (including Blindness)	<input type="checkbox"/> Speech or Language Impairment	
<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Deaf-Blindness	<input type="checkbox"/> Other Health-Impairment	
<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Deafness	<input type="checkbox"/> Orthopedic Impairment	

4) Check each Related and Other Services currently approved by SED for this program:

<input type="checkbox"/> Speech/Language Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Psychological Services
<input type="checkbox"/> School Social Work	<input type="checkbox"/> Counseling	<input type="checkbox"/> Vision Services
<input type="checkbox"/> Audiology Services	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

5) Number of hours of **daily instruction excluding** the lunch period: _____.

³ State-operated or State-supported schools only

Section C-2: Half-Day Special Class (9010) – Proposed Modification(s)

Directions: Complete the information below indicating the **proposed modification(s)** the agency is requesting for its existing extended school year July/August half-day (9000) special class program model:

- 1) Complete the chart below with the proposed staffing ratio and indicate the number of classes of each, **including any approved classes the agency proposes to continue operating in addition to requesting (a) new staff/student ratio class/classes:**

Staffing Ratio	<input type="checkbox"/> 15:1	<input type="checkbox"/> 12:1 ⁴	<input type="checkbox"/> 12:1+1	<input type="checkbox"/> 6:1+1	<input type="checkbox"/> 8:1+1	<input type="checkbox"/> 12:1+ (3:1)	<input type="checkbox"/> Other:
Number of Classes at Each Staffing Ratio							

- 2) Proposed Age (range) of student(s): _____ to _____

- 3) Check each disability the agency proposes to add to its existing program model:

<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Multiple Disabilities	<input type="checkbox"/> Autism
<input type="checkbox"/> Emotional Disturbance	<input type="checkbox"/> Visual Impairment (including Blindness)	<input type="checkbox"/> Speech or Language Impairment	
<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Deaf-Blindness	<input type="checkbox"/> Other Health-Impairment	
<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Deafness	<input type="checkbox"/> Orthopedic Impairment	

- 4) Check each Related/Other Service the agency proposes to add to the existing program:

<input type="checkbox"/> Speech/Language Therapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Psychological Services
<input type="checkbox"/> School Social Work	<input type="checkbox"/> Counseling	<input type="checkbox"/> Vision Services
<input type="checkbox"/> Audiology Services	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

- 5) Proposed revised number of hours of **daily instruction**: _____

Section D: Program Description: Please provide a description of the reason(s) for the program modification(s) [use additional sheets if necessary]:

⁴ State-operated or State-supported schools only

