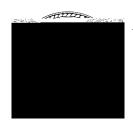
THE STATE EDUCATION DEPARTMENINIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12



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SPECIAL EDUCATION QUALITY ASSURANCE
NONDISTRICT UNIT
89 Washington Avenue, Room (SAB) (NY 12234
Telephor(618) 478185
www.p12.nysed/gp@cialed

1 Park Place, Floor, Peekskill, NY 10566 Telephone (9140) 29900

APPLICATION FOR TUITION ASSISTANCE PROGRAM FOR DEAF INFANTS

Infant's Name:				9	☐ F Sex: ☐ M
	(Last)		(First)		30X IVI
Date of Birth:		(Day)	Age	in Months: _	
How long has this i	infant been a resid	tent of New Yor	k State?		
	STATEMENT (OF PARENT C	OR LEGAL GUARDIA	AN	
admission approved a and for Sta	for my deaf infa agency) te assistance for	ant to the dea	ove-named infant, has infant program at educational program Education Departme	(fill in name	e of rant
Signature:			Date		
Address:					
	(Street)		(City)	(State)	(Zip Code)
County:	Telephone Number:				
, V WKLV W	KH FKLOG¶	V SULPDU	J ☐ Yes ☐ No		
,I QR ZKD\	W LV WKH I	FKLOG¶V	SUL		