**Preschool Program Modification Request Application**

**For New York State Education Department Approval**

**To Expand and/or Modify an**

**Approved Preschool Special Education and/or**

**Multidisciplinary Evaluation Program**

**New York State Education Department**

**Office of P-12 Education: Office of Special Education**

**89 Washington Avenue, Room 309 EB**

**Albany, NY 12234**

**518-473-6108**

[**OSEapplications@nysed.gov**](mailto:SPECED@MAIL.NYSED.GOV)

**<https://www.nysed.gov/special-education>**

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**Preschool Program Modification Application**

**INSTRUCTIONS**

**The information contained in this instruction packet is organized according to the following steps in the application process:**

**Step 1: Before Submitting An Application**

**Step 2: Completing The Application**

**Step 3: How To Submit The Completed Application**

**Step 4: Application Review and Approval Process**

**Step 1: Before Submitting An Application**

1. **Read all instructions carefully**. Incomplete applications or missing documentation will result in delays in the approval process.
2. Applicants may not need to complete all sections of this application. Consult the chart on page 4 which identifies the sections which must be completed based on the type of modification requested.
3. Modifications which include an expansion of services or geographic region must first provide the Special Education Quality Assurance (SEQA) Regional Associate with documentation that there is demonstrated need for the expansion of preschool services in the geographic region of the State in which the program is located. If regional need is confirmed, the Regional Associate will complete and provide to the applicant a Determination of Regional Need form which **must be attached** to this application. For further information see:

<http://www.nysed.gov/special-education/documentation-preschool-regional-need>.

**Step 2: Completing The Application**

**\* Please Read Instructions Carefully and Provide All Requested Information. \***

**Applications must be typed.**

To use the application as a “Form” document, it must be in restricted format.

* If using Word 2003, you must save it in a ‘lock’ mode as a form. First, ensure that the Forms toolbar is available: go to View, scroll to Toolbar and verify that Forms is checked.To lock the form, hit the lock icon.



* If using Word 2010, under the Developer tab on the ribbon, select “Restrict Editing”, check the box under number 2 and select “Filling in forms” from the drop-down box.

To enter information into the form, hit the “tab” key to bring you to the form field and type the information needed. Tab to the next form field. Save the document in locked form. If you unlock the document in the process of completing the application, you may lose already entered information.

**Do not leave any applicable items blank. Mark items that are not applicable as “N/A”.**

Where the application calls for a narrative response, please type the response on the application form itself. **Please do not indicate that the response is provided in an** **attachment**, unless an attachment is specifically requested in the application.

NYSED will only initiate its review of the Preschool Program Modification Application if all components of the application are completed and the required documentation is provided.

* Multiple modification requests from one program provider should be submitted on the same application form. The required documentation for each modification type must be included.
* Follow instructions for completing each required section as indicated in the application.
* For program-related questions, contact your New York State education Department (NYSED) SEQA Regional Associate. For SEQA contact information, see <http://www.nysed.gov/special-education/special-education-quality-assurance-regional-offices>.

**Step 3: How To Submit The Completed Application**

Before submitting the application, please confirm all required information and attachments have been provided.

Please send of the completed application and supporting documents to:

[**OSEapplications@nysed.gov**](mailto:OSEapplications@nysed.gov)

***PLEASE NOTE:*** *APPLICATIONS THAT DO NOT INCLUDE ALL DOCUMENTATION AT THE TIME OF SUBMISSION WILL BE CONSIDERED INCOMPLETE AND WILL NOT BE PROCESSED.*

Questions concerning the completion or submission of this application may be directed to the P-12: Office of Special Education Preschool Policy Unit at (518) 473-6108.

**Step 4: Modification Application Review and Approval Process**

* It is NYSED’s intent to process Preschool Modification Applications and issue amended approval letters within 45 calendar days of receipt of a complete form.
* Agencies and school districts may not implement the proposed modification request until written notification of approval by NYSED has been received. This approval will only be granted after the notification request is found to be consistent with applicable law and regulation.

Preschool Program Modification Application

For New York State Education Department Approval

To Expand and/or Modify an

Approved Preschool Special Education and/or

Multidisciplinary Evaluation Program

**Required Information:** The following information will be used to communicate with the applicant during the review of the application and for New York State Education Department (NYSED) electronic mailings.

|  |  |
| --- | --- |
| **Date submitted:** |  |
| **Name of Applying Entity:** |  |
| **Key contact person(s):** |  |
| **Email:** |  |
| **Telephone number:** |  |

|  |
| --- |
| **CERTIFICATION AND ASSURANCES STATEMENT** |

**Required Information: To be completed and signed by all applicants:**

**Name of Approved Preschool Program:**      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby certify that I will comply with the requirements of section 4410 of the Education Law and Parts 200 and 201 of the Regulations of the Commissioner of Education and understand the program and fiscal requirements for operating a preschool special education program.

The applicant also make(s) the following assurances pursuant to the Individuals with Disabilities Education Act (IDEA), section 4410 of the Education Law and Parts 200 and 201 of the Regulations of the Commissioner of Education:

* Parents of students shall not be asked to make any payments in lieu of, in advance of or in addition to, State, school district or county payments for allowable costs for students placed according to New York State procedures.
* Instructional and evaluation materials to be used in the programs will be available in a usable alternative format, which shall meet the National Instructional Materials Accessibility Standard for each preschool student with a disability in accordance with the student’s individualized education program (IEP).
* The approved program(s) and evaluators shall not issue, or cause to be issued, false advertising with respect to the services to be provided to preschool children and their families.
* The approved program(s) and evaluators shall not use any form of corporal punishment, aversive interventions, or seclusion, as such terms are defined in 8 NYCRR section 19.5, to modify a student’s behavior.
* The program will, as applicable, provide each preschool student served with all of the special programs and services recommended in the student’s IEP at the recommended frequency, duration, location and intensity.
* The approved program shall cooperate with the municipality, school district, NYSED and other State oversight agencies in monitoring for compliance, effectiveness and fiscal integrity of the program.
* The program shall provide data, records and reports to the referring school district, NYSED, the municipality and other State fiscal and program oversight agencies upon request.
* The program will conform to all applicable fire and safety regulations of the State and municipality in which the program is located.
* All board members and owners of private for-profit and not-for-profit agencies shall complete NYSED training regarding their legal, fiduciary and ethical responsibilities within the first year of obtaining their role following approval of the program by NYSED or within one year of such training being made available by the NYSED, whichever is later.
* The executive director, or any individual that will sign or certify the Consolidated Fiscal Report (CFR) on behalf of the program, shall complete annual on-line CFR training as required by NYSED.
* An executive director who is paid as a full time executive director shall be employed in a full-time, full-year position and shall not engage in activities that would interfere with or impair the executive director’s ability to carry out and perform his or her duties, responsibilities and obligations.
* No preschool student with a disability shall be removed or transferred from an approved program without the approval of the school district contracting for education of such student.
* The owner or operator of an approved program who intends to cease the operation of such school or chooses to transfer ownership, possession or operation of the premises and facilities of such school or to voluntarily terminate its status as an approved school, shall submit to the Commissioner of Education written notice of such intention not less than 90 days prior to the intended effective date of such action with a detailed plan which makes provision for the safe and orderly transfer of each student with a disability who was publicly placed in such approved school in accordance with 8 NYCRR section 200.7(e).
* Changes to the program’s approval will not be implemented without prior approval by NYSED.

I hereby certify that the information submitted in this application is true to the best of my knowledge and belief; and further, I understand that the program as modified shall operate consistent with the conditions of approval and in conformance with all applicable federal and State laws, regulations and policies; shall provide quality services in a necessary and cost-efficient manner and in the least restrictive environment; and shall operate in conformance with the requirements of the Reimbursable Cost Manual of NYSED.

|  |  |
| --- | --- |
| Signature: |  |
| Date: |  |
| Print/Type Name and Title: |  |

|  |
| --- |
| **Preschool Modification Application – Submission Requirements** |

|  |  |  |
| --- | --- | --- |
| ***Complete the identified sections:*** | ***As required or If you are changing any of the following:*** | ***Check all that apply to this application:*** |
| **Contact Information** | **Required for all applicants** | **✓** |
| **Certification and Assurances** | **Required for all applicants** | **✓** |
| **Section 1:**  **Applicant Information**  **Items 1-8** | **Required for all applicants** | **✓** |
| **Items 9-15** | **Required only for** changes to Applicant Information   * Agency Name * Contact information * Ownership * Chief Executive(s)/Chief School Officials * Chief Financial Officer * Certified Public Accountant Firm |  |
| **Section 2:**  **Location/Site Information** | **Required only for** proposed changes in Location/Site Information   * Additional site * Removing a previously approved site |  |
| **Section 3:**  **Program Operation\***  **MDE**  **SEIS**  **SCIS**  **SC** | **Required only for** proposed changes to Program Operation   * Geographic Region to be Served * Class Size * Hours of Operation * Population to be Served * Number of Classes (Reduction or Expansion) |  |
| **Section 4:**  **Program Budget** | **Required only for** proposed changes to SCIS and/or SC programs that affect the current certified tuition rate(s) and meet the criteria for rate appeals |  |
| **Section 5:**  **Character and Competence** | **Required only for** change in the Chief Executive Officers/Chief School Officials/Owners |  |
| **Section 6:**  **Governance** | **Required only for** change to the ownership of the provider agency\*\* |  |
| \* MDE - Multidisciplinary Evaluation, SEIS – Special Education Itinerant Services, SCIS – Special Class in an Integrated Setting, SC – Special Class | | |
|  | | |
| **Please Note:** If you area currently approved preschool special education program provider that wishes to add a component program model type (i.e., MDE, SEIS, SCIS or SC) for which your agency is not currently approved, you should not submit this Preschool Modification Application. You must instead submit an *Initial Application for New York State Education Department Approval to Operate a Preschool Special Education Program* available at <http://www.nysed.gov/special-education/preschool-applications>. | | |
|  | | |
| **\*\*Please Note:** Separate procedures are required for transfer of ownership, possession or operation, or voluntary termination of an approved preschool (8 NYCRR section 200.7(e)). Notify the Preschool Policy Unit in writing at least 90 days prior to the intended effective date of such action. | | |

**Instructions: Use this chart to identify the sections of the Preschool Modification Application you must complete.**

|  |
| --- |
| **Section 1: Applicant Information** |

All Applicants must complete items 1-8. Complete items 9-15 if you are notifying NYSED of any changes to those items.Place a check in the box beside the number (e.g., 1. ) for those item(s) which have changed since issuance of previous program approval letter.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. | Legal Name of Applying Agency | | | | | | |
| 2. | Assumed Name or Doing Business As (DBA), if applicable | | | | | | |
| 3. | Mailing Address of Agency Administrative Office | Street | | | | | |
|  |  | City State Zip Code | | | | | |
| 4. | County and School District where Administrative Office is Headquartered | County | | | | | |
|  |  | School District | | | | | |
| 5.  6. | Telephone/Email Address of Administrative Office  Area Code       Number       Ext.  Email Address | | | | Fax Number of Administrative Office  Area Code       Number | | |
|  | |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |   Federal ID Number | | | | | | |
|  | Agency/District 12-digit NYSED Code   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  | | | | | | | |
| 9. | Name and Title of Chief Executive(s)/Chief School Official(s) (CEO) | Name | | | | | |
|  |  | Title | | | | | |
|  |  | Telephone | Fax Number | | | | Email Address |
|  | Primary residence of CEO | City | | | | | State |
|  | Contact Person for the Evaluation/Education Program | Name | | | | | |
|  |  | Title | | | | | |
|  |  | Telephone | | Fax Number | | Email Address | |
| 12. | Chief Financial Officer (CFO) | Name | | | | | |
|  |  | Title | | | | | |
|  |  | Telephone | | Fax Number | | Email Address | |
| 13. | Certified Public Accountant (CPA) Firm | Name of CPA Firm  Name of CPA | | | | | |
|  |  | Title | | | | | |
|  |  | Telephone | | Fax Number | | Email Address | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 14. | Hours of Operation | Current: | Proposed: | |
| 15a. | 15a.  Private Entity  Public Entity | Corporation (Specify Type and Date of Incorporation) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Partnership (Specify Type and Date of Formation) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Professional Limited Liability Company (PLLC) (Specify:      )  Limited Liability Company (LLC) (Specify:      )  Other (Specify Type and Date of Formation) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  School District  Board of Cooperative Educational Services (BOCES)  State Agency  County or Municipal Government Agency | | |
| 15b. | 15 b. Indicate whether this is a domestic or foreign entity? | Domestic  Foreign | | |
| 15c. | 15c.  For Profit  Nonprofit | Certification of Incorporation with purpose section or registration pursuant to New York Business Law  Certificates or Amendments along with the related consent(s) of the Commissioner of Education  Articles of Organization (PLLC, LLC)  Regents Charter  Education Corporation (Regents Certificate of Incorporation)  Other not-for-profit corporation or organization | |

**If there are any changes to items 15a and/or 15c, applicant must attach as applicable:** a copy of the Certification of Incorporation with purpose section or registration pursuant to New York Business Law, Certificates or Amendments along with the related consent(s) of the Commissioner of Education, Articles of Organization (for PLLC, LLC), Regents Charter, Regents Certificate of Incorporation, or other legal authorizing documents if operating under another State agency or another not-for-profit structure. Also attach any related amendments, certificates of assumed name, and tax exempt documentation from the Internal Revenue Service (IRS).

|  |
| --- |
| **Section 2: Site Information** |

Complete this section if you are proposing any changes to administrative, assessment and/or instructional locations. Copy and attach additional pages if necessary.

|  |
| --- |
| Describe the proposed modification and provide a narrative rationale for the proposed change.  If your program is located in a New York City School District, indicate the regional need from the current posting (type of program, ratio if applicable, language, and community school district(s) in which the need is identified). |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Site 1:**  please check if there is no prior approval for any preschool special education services at this site in this county | | Owned  Leased / Rented | Adding this site  Deleting this site  Change in contact information |
| **Street** | | | |
| **City State Zip Code** | | | |
| **County School District/NYC Community School District** | | | |
| **Name and Title of Site Supervisor** | | | |
| **Telephone** | **Email Address** | | |
| **Purpose of Site (check all that apply)**  Administration (e.g., administrator’s offices, staff offices, record storage)  Evaluation Site  Special Class(es) in Integrated Setting  Special Class(es) | | | |
| **Is this building used for any other purpose**  No  Yes (specify): | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Site 2:**  please check if there is no prior approval for any preschool special education services at this site in this county | | Owned  Leased / Rented | Adding this site  Deleting this site  Change in contact information |
| **Street** | | | |
| **City State Zip Code** | | | |
| **County School District/NYC Community School District** | | | |
| **Name and Title of Site Supervisor** | | | |
| **Telephone** | **Email Address** | | |
| **Purpose of Site (check all that apply)**  Administration (e.g., administrator’s offices, staff offices, record storage)  Evaluation Site  Special Class(es) in Integrated Setting  Special Class(es) | | | |
| **Is this building used for any other purpose**  No  Yes (specify): | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Site 3:**  please check if there is no prior approval for any preschool special education services at this site in this county | | Owned  Leased / Rented | Adding this site  Deleting this site  Change in contact information |
| **Street** | | | |
| **City State Zip Code** | | | |
| **County School District/NYC Community School District** | | | |
| **Name and Title of Site Supervisor** | | | |
| **Telephone** | **Email Address** | | |
| **Purpose of Site (check all that apply)**  Administration (e.g., administrator’s offices, staff offices, record storage)  Evaluation Site  Special Class(es) in Integrated Setting  Special Class(es) | | | |
| **Is this building used for any other purpose**  No  Yes (specify): | | | |

**Required documentation if modification includes adding sites:**

(Copy and attach additional forms, if more than three sites are being added.)

**A. Health and Safety Compliance**

|  |  |
| --- | --- |
| **Documentation Required** | **Attached** |
| 1. Certificate of Occupancy | Site 1:  Site 2:  Site 3: |
| 1. Fire Inspection Reports (must be current, within the past year). If report indicates noncompliance in any area, submit documentation that noncompliance was resolved.[[1]](#footnote-1) | Site 1:  Site 2:  Site 3: |
| 3. Building Inspection Reports (must be current, within the past year). If report indicates noncompliance in any area, submit documentation that noncompliance was resolved. | Site 1:  Site 2:  Site 3: |
| 4. Fire/Disaster Evacuation Plan including procedures to evacuate nonambulatory individuals (For more information, see <https://www.p12.nysed.gov/facplan/articles/EmergencyEvacuation2.htm>). | Site 1:  Site 2:  Site 3: |
| 5. Is the building used for instructional purposes or for conducting evaluations in the summer? | No attachment needed.  **Yes No**  Site 1:  Site 2:  Site 3: |
| If yes, is the building air conditioned?  If no, describe for each site how climate will be controlled to ensure students can comfortably and safely attend during the summer months. | **Yes** **No** **NA**  Site 1:  Site 2:  Site 3: |

**B. Floor Plans**

| **Documentation Required** | **Attached** | | |
| --- | --- | --- | --- |
|  | **Yes** | **N/A** |
| Submit clear, legible line drawings showing the floor plans, which need not be blueprint quality. If there are multiple sites, attach one line drawing for each site. Information on line drawings must clearly indicate:  a. Preschool special education program room labels and square footage for each space:   * Office space (indicate number of staff designated in each space/room)   + Administrative   + Staff * Related services space   + Therapy type   + Instructional group size(s) * Classrooms   + Classroom staff to student ratio to be served * Other spaces, for example   + Record storage   + Staff lounge   + Maintenance   + Utilities   b. Building space utilized for purposes other than preschool special education:   * Early childhood programs * Day care * Adult programs * Community agencies * Public vendors/shops/business * Other (specify on plans) | Site 1: |  |  |
| Site 2: |  |  |
| Site 3: |  |  |
|  |  |  |
|  |  |  |

**C. Accessibility**

| **Information Required** |  | **Yes** | **No** |
| --- | --- | --- | --- |
| 1. Exterior Routes: People with disabilities should be able to arrive on site, approach the building, and enter as freely as everyone else. At least one route of travel should be safe and accessible for everyone, including people with disabilities. This route must include handicapped parking, curb cuts, ramps, and automatic door operators as necessary to enter the building.  For each site, identify whether there is an accessible exterior route as specified above. | Site 1: |  |  |
| Site 2: |  |  |
| Site 3: |  |  |
|  |  |  |
| 2.Interior Route, Access to Goods and Services, and Restroom Facilities: The layout of the building should allow people with disabilities to obtain materials or services and use the facilities without assistance. This should include access to general purpose and specialized classrooms, public assembly spaces (such as libraries, gymnasiums, and auditoriums), nurse’s office, main office, and restroom facilities. Services include drinking fountains, telephones, and other amenities.  For each site, identify whether there is an accessible interior route as specified above. | Site 1: |  |  |
| Site 2: |  |  |
| Site 3: |  |  |
|  |  |  |
|  |  |  |
| **Documentation Required** | **Attached (Y/NA)** | | |
| **Site 1** | **Site 2** | **Site 3** |
| 3. Accessibility based on the Americans with Disabilities Act (ADA) |  |  |  |
| a. Architect’s letter submitted by architect or engineer or organization familiar with public buildings and ADA |  |  |  |
| b. If any areas have been identified as noncompliant with ADA, include evidence of resolution of the issues |  |  |  |
| c. Or, submit a written plan of how you will accommodate persons with disabilities in accessing the functions and/or services provided in the building. |  |  |  |

|  |
| --- |
| **Section 3: Program Operation Modification(s)** |

1. **Multidisciplinary Evaluation Program (MDE)**

|  |  |  |
| --- | --- | --- |
| **Currently approved** | **No changes** | **Modification(s) requested** |

* Change in geographic area to be served (must include *Determination of Regional Need* signed by SEQA Regional Office in proposed geographic area)
* Change in hours of operation of the program
* Change in the scope of assessments (e.g., bilingual)
* Changes in staffing

|  |
| --- |
| Describe the proposed modification and provide a narrative rationale for the proposed change. If your program is located in a New York City School District, indicate the regional need from the current posting (type of program, ratio if applicable, language, and community school district(s) in which the need is identified). |
| 1. Describe the additional projected number of students to be evaluated annually by the program. |
| 1. Describe the overall staffing configuration (current and proposed), including the types of evaluations to be conducted.     For proposed changes in the type(s) of evaluations available (e.g., adding vision screenings, assistive technology evaluations), complete the following:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Evaluation Components** | **Types of NYS Certification(s) and/ or License(s) Required of Evaluator(s)** | **Specify Staff (S) or Contract (C)** | **Specify Language and Certification of**  **Bilingual Evaluator** | **Projected Number of Evaluations**  **Per Week** | | Physical Exam |  |  |  |  | | Social History |  |  |  |  | | Psychological |  |  |  |  | | Student Observation |  |  |  |  | | Other evaluation components (list below): |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |
| 1. If the agency is proposing to expand services to an additional geographic area, describe how the program will ensure appropriate administrative and clinical supervision of the evaluation process. |
| 1. If the agency is proposing to change the hours of operation, identify the daily hours in the chart below:  |  |  |  | | --- | --- | --- | | **Day** | **Start Time** | **Finish Time** | | Monday |  |  | | Tuesday |  |  | | Wednesday |  |  | | Thursday |  |  | | Friday |  |  | |
| 1. In what additional county(ies) is the program proposing to provide MDEs?[[2]](#footnote-2)     **Attach Determination of Regional Need.** |
| 1. Other information relevant to the proposed modification of the MDE program: |

1. **Special Education Itinerant Services (SEIS)**

|  |  |  |
| --- | --- | --- |
| **Currently approved** | **No changes** | **Modification(s) requested** |

* Change in geographic area to be served – expansion or reduction (for expansion, applicant must include *Determination of Regional Need* signed by SEQA Regional Office in proposed geographic area)
* Change in hours of operation of the program
* Change in proposed population to be served
* Change in the scope of assessments (e.g., bilingual)
* Changes in staffing

|  |
| --- |
| 1. Describe the proposed modification and provide a narrative rationale for the proposed change. If your program is located in a New York City School District, indicate the regional need from the current posting (type of program, ratio if applicable, language, and community school district(s) in which the need is identified). |
| 1. Describe the additional projected number of students to be served by the program.   Current enrollment:       Projected enrollment: |
| 3. Describe changes relating to the population to be served.  Current enrollment:       Projected enrollment:  Student Management Needs:  Check each box which identifies the new population(s) you are proposing to serve.  Students will primarily need specialized instruction and will not have management needs that interfere with the instructional process.  Students’ management needs will be highly intensive, requiring a high degree of individualized attention and intervention.  Students’ management needs will be intensive and require a significant degree of individualized attention and intervention.  Students will have severe multiple disabilities and their programs will consist primarily of habilitation and treatment.  Briefly describe in narrative form, how this new population differs from the profile of current students served. Include general descriptions of students’ levels of functioning in social-emotional skills; early language/communication and early literacy; and use of appropriate behaviors to meet their needs. |
| 4. For proposed expansion to additional geographic regions, describe how many additional special education teachers the program proposes to employ to provide SEIS.    **Attach a representative sample weekly schedule for the additional special education teacher(s) providing SEIS.** |
| 5. Describe the projected caseload of the additional special education teacher(s) providing SEIS (e.g., number of students). |
| 6. Identify the regular daily hours of operation for the program in the expanded geographic region:   |  |  |  | | --- | --- | --- | | **Day** | **Start Time** | **Finish Time** | | Monday |  |  | | Tuesday |  |  | | Wednesday |  |  | | Thursday |  |  | | Friday |  |  |     Describe any circumstances when services may extend beyond the program’s regular daily hours: |
| 7. Identify the additional school district(s) and/or county(ies) where SEIS will be provided.[[3]](#footnote-3)    **Attach Determination of Regional Need** |

1. **Special Class in an Integrated Setting (SCIS)**

|  |  |  |
| --- | --- | --- |
| **Currently approved** | **No changes** | **Modification(s) requested** |

* Change to the total number of SCIS classes - expansion or reduction (for expansion, applicant must include *Determination of Regional Need* signed by SEQA Regional Office)
* Change in hours of operation
* Change in class size (student to staff ratios) - (if this results in an expansion, applicant must include *Determination of Regional Need* signed by SEQA Regional Office in proposed geographic area)
* Change in hours of operation/school calendar
* Change to regular early childhood program or provider
* Change to staffing

|  |
| --- |
| 1. Describe the proposed modification and provide a narrative rationale for the proposed change(s). If your program is located in a New York City School District, indicate the regional need from the current posting (type of program, ratio if applicable, language, and community school district(s) in which the need is identified). |
| 1. Describe changes relating to the population to be served.   Current enrollment:       Projected enrollment:  Student Management Needs:  Check each box which identifies the new population(s) you are proposing to serve.  Students will primarily need specialized instruction and will not have management needs that interfere with the instructional process.  Students’ management needs will be highly intensive, requiring a high degree of individualized attention and intervention.  Students’ management needs will be intensive and require a significant degree of individualized attention and intervention.  Students will have severe multiple disabilities and their programs will consist primarily of habilitation and treatment.  Briefly describe in narrative form, how this new population differs from the profile of current students served. Include general descriptions of students’ levels of functioning in social-emotional skills; early language/communication and early literacy; and use of appropriate behaviors to meet their needs. |
| 1. Identify the total number of SCIS classes proposed.   Current Half-day classes:       Proposed Half-day classes:  Current Full-day classes:       Proposed Full-day classes:  **Attach Determination of Regional Need.** |
| 1. Describe changes to the proposed class size(s) (staff-to-student ratio).  |  |  |  | | --- | --- | --- | | Staff-to-Student  classroom ratios (e.g., 6:1:2) | Current number  of classes | Proposed number  of classes | |  |  |  | |  |  |  | |  |  |  | |  |  |  |   Complete the chart below to report the projected numbers of students with disabilities to students without disabilities[[4]](#footnote-4). |
| **SCIS Classroom Student/Staff Data:** Note that the number of students with disabilities to students without disabilities should generally be equal.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Classroom Data** | **Proposed SCIS Classes** | | | | | **1** | **2** | **3** | **4** | | **Check One:**  **Half-day**  **Full-day** | **Check One:**  **Half-day**  **Full-day** | **Check One:**  **Half-day**  **Full-day** | **Check One:**  **Half-day**  **Full-day** | | Number of Preschool Students With a Disability |  |  |  |  | | Number of Preschool Students Without a Disability |  |  |  |  | | Number of Certified Special Education Teachers |  |  |  |  | | Number of Early Childhood Education Teachers |  |  |  |  | | Number of Supplementary School Personnel – teaching assistants and teacher aides |  |  |  |  | |
| 1. Identify change(s) in the regular early childhood program (e.g., Head Start, Universal Prekindergarten) which affect the need for this modification?     **Attach the program and fiscal collaborative agreement(s)** |
| 1. Proposed changes to related services to be provided to meet the individualized education programs (IEPs) of students enrolled in the program[[5]](#footnote-5).     Identify the projected caseloads (numbers only) of related services providers. |
| 1. Proposed Changes to Program Schedules   Check as applicable:  Change(s) from Full Day to Half Day  Change(s) from Half Day to Full Day  Adding SCIS class(es)  Half-day program(s)  *Half-day programs must provide instruction for a half-day session. A half-day session is defined as a morning or afternoon session with not less than 2½ hours of instruction.*  Full-day program(s)  *Full-day programs must provide instruction for a full-day session. A full-day session is defined as a school day with not less than five hours of instruction. The Commissioner may, based on documented justification, approve a full-day program to provide instruction for less than a full-day session, but more than a half-day session.*  **Attach a sample daily schedule of instructional activities from arrival to dismissal. Note that each school day must provide the minimum hours of instruction, including related services, but excluding transportation and lunch.**  Complete the following for **HALF-DAY** SCIS programs:   |  | **Morning Class**  **Instructional Time** | | **Afternoon Class**  **Instructional Time** | | | --- | --- | --- | --- | --- | | **Start** | **Finish** | **Start** | **Finish** | | Monday |  |  |  |  | | Tuesday |  |  |  |  | | Wednesday |  |  |  |  | | Thursday |  |  |  |  | | Friday |  |  |  |  |   Complete the following for **FULL-DAY** SCIS programs:  Proposed total number of instructional hours per day for the full-day program:   |  | **Morning**  **Instructional Time** | | **Afternoon**  **Instructional Time** | | | --- | --- | --- | --- | --- | | **Start** | **Finish** | **Start** | **Finish** | | Monday |  |  |  |  | | Tuesday |  |  |  |  | | Wednesday |  |  |  |  | | Thursday |  |  |  |  | | Friday |  |  |  |  |   If proposing a full-day program that will provide instruction for less than a five hour day session, provide a justification below: |
| 1. For proposed SCIS programs planning to serve three or more children for more than three hours per day, a Day Care license or Registration Certificate must be attached.   **Attach Day Care License or Registration Certificate** |

1. **Special Class (SC)**

|  |  |  |
| --- | --- | --- |
| **Currently approved** | **No changes** | **Modification(s) requested** |

* Change to the total number of SC classes - expansion or reduction (for expansion, applicant must include *Determination of Regional Need* signed by SEQA Regional Office)
* Change in hours of operation
* Change in class size (student to staff ratios) - (if this results in an expansion, applicant must include *Determination of Regional Need* signed by SEQA Regional Office in proposed geographic area)
* Change in hours of operation/school calendar
* Change to regular early childhood program or provider
* Change to staffing
* Change to population to be served

|  |
| --- |
| 1. Describe the proposed modification and provide a narrative rationale for the proposed change(s). If your program is located in a New York City School District, indicate the regional need from the current posting (type of program, ratio if applicable, language, and community school district(s) in which the need is identified). |
| 1. Describe changes relating to the population to be served.   Current enrollment:       Projected enrollment:  Student Management Needs:  Check each box which identifies the new population(s) you are proposing to serve.  Students will primarily need specialized instruction and will not have management needs that interfere with the instructional process.  Students’ management needs will be highly intensive, requiring a high degree of individualized attention and intervention.  Students’ management needs will be intensive and require a significant degree of individualized attention and intervention.  Students will have severe multiple disabilities and their programs will consist primarily of habilitation and treatment.  Briefly describe in narrative form, how this new population differs from the profile of current students served. Include general descriptions of students’ levels of functioning in social-emotional skills; early language/communication and early literacy; and use of appropriate behaviors to meet their needs. |
| 1. Identify the total number of Special Classes.   Current Half-day classes:       Proposed Half-day classes:  Current Full-day classes:       Proposed Full-day classes:  **Attach Determination of Regional Need.** |
| 1. Describe changes in proposed special class size(s) (student-to-staff ratio(s))[[6]](#footnote-6). (e.g., 12:1+1 meaning 12 students to one teacher to one teaching assistant).  |  |  |  | | --- | --- | --- | | Staff-to-Student  classroom ratios (e.g., 6:1+2) | Current number  of classes | Proposed number  of classes | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |
| **Special Class Student/Staff Data**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Classroom Data** | **Proposed SC Classes** | | | | | **1** | **2** | **3** | **4** | | **Check One:**  **Half-day**  **Full-day** | **Check One:**  **Half-day**  **Full-day** | **Check One:**  **Half-day**  **Full-day** | **Check One:**  **Half-day**  **Full-day** | | Number of Preschool Students With a Disability |  |  |  |  | | Number of Certified Special Education Teachers |  |  |  |  | | Number of Supplementary School Personnel – teaching assistants and teacher aides |  |  |  |  |   The maximum class sizes must be consistent with section 200.6(h)(4) of the Regulations of the Commissioner of Education and be proposed as one or more of the following:   * 12 students to one teacher (plus additional staff) * 8 students to one teacher (plus additional staff) * 6 students to one teacher (plus additional staff)   No other class size options will be considered (e.g., 7 students to one teacher plus additional staff). |
| 1. For additional classes and/or changes in proposed population, list the related services to be provided to meet the IEPs of students enrolled in the program.[[7]](#footnote-7)     Identify the projected caseloads (numbers only) of related services providers. |
| 6. Proposed Changes to Program Schedules  Check as applicable:  Change(s) from Full Day to Half Day  Change(s) from Half Day to Full Day  Adding Special Class(es)  Half-day program(s)  *Half-day programs must provide instruction for a half-day session. A half-day session is defined as a morning or afternoon session with not less than 2½ hours of instruction.*  Full-day program(s)  *Full-day programs must provide instruction for a full-day session. A full-day session is defined as a school day with not less than five hours of instruction. The Commissioner may, based on documented justification, approve a full-day program to provide instruction for less than a full-day session, but more than a half-day session.*  **Attach a sample daily schedule of instructional activities from arrival to dismissal**. Note that each school day must provide the minimum hours of instruction, including related services, but excluding transportation and lunch.  **Complete the following for HALF-DAY SC programs.**   |  | **Morning Session**  **Instructional Time** | | **Afternoon Session**  **Instructional Time** | | | --- | --- | --- | --- | --- | | **Start** | **Finish** | **Start** | **Finish** | | Monday |  |  |  |  | | Tuesday |  |  |  |  | | Wednesday |  |  |  |  | | Thursday |  |  |  |  | | Friday |  |  |  |  |   Notations: (optional)  **Complete the following for FULL-DAY SC programs.**  Proposed total number of instructional hours per day for the full-day program:   |  | **Morning Instructional Time** | | **Afternoon**  **Instructional Time** | | | --- | --- | --- | --- | --- | | **Start** | **Finish** | **Start** | **Finish** | | Monday |  |  |  |  | | Tuesday |  |  |  |  | | Wednesday |  |  |  |  | | Thursday |  |  |  |  | | Friday |  |  |  |  |   Notations: (optional)  If proposing a full-day program that will provide instruction for less than a five hour day session, provide a justification below: |
| 7. For SC programs planning to serve three or more children for three or more hours per day, a Day Care License or Registration Certificate must be attached.  **Attach Day Care License or Registration Certificate** |

|  |
| --- |
| **Section 4: Budget Information** |

**Required only as applicable for proposed changes of SCIS and/or SC programs that affect the current certified tuition rate(s) and meet the criteria for rate appeals pursuant to Section 200.9(f)(3)(i) of the Regulations of the Commissioner of Education.**

**Schedule 1: Projected Personal Services**

In Schedule 1, report projected salaries of Nondirect Care (Administration/Facility) and Direct Care (Instructional, Social Services and Related Services) staff by job classification using the applicable job titles listed below as a guide. These job titles may also be found in Appendix R (pgs. 134-143) of the Consolidated Fiscal Report Manual at: <http://www.oms.nysed.gov/rsu/Manuals_Forms/Manuals/CFRManual/home.html>.

The total salaries must reconcile with the projected expenditures reported on line 1, "Salaries," on Schedule 4 "Projected Expenditures."

**Nondirect vs. Direct Care Position Classifications**

|  |  |
| --- | --- |
| **Nondirect Care Positions** | **Direct Care Positions** |
| Executive Director/Superintendent | Teacher – Substitute |
| Finance Director/Business Official | Teacher – Special Education |
| Program Administrator/Supervisor | Teacher – Early Childhood Program |
| Administrator | Teaching Assistant, Teacher Aide – Students with Disabilities |
| Accountant/Bookkeeper | Teaching Assistant, Teacher Aide – Early Childhood Program |
| Office Related | Psychologist |
| Maintenance Worker | Social Worker |
| Other (Specify) | Speech and Language Pathologist |
|  | Physical Therapist |
|  | Occupational Therapist |
|  | Occupational or Physical Therapy Assistants |
|  | Other (Specify) |

The full-time equivalent (FTE) should be rounded to three decimal places (.000). The standard formula for calculating an employee's FTE is as follows:

|  |
| --- |
| Total Hours of Projected Employment  Standard work Week Hours x 52 Weeks |

1. **Special Class in an Integrated Setting (SCIS)** – Complete Schedules 1, 2, 3 and 4 if the proposed change for the SCIS program affects the current certified tuition rate and meets the criteria for rate appeal.

**Section Not Applicable**

**Schedule 1: Projected Personal Services - SCIS**

**Nondirect Care – Administration/Facility - SCIS**

|  |  |  |
| --- | --- | --- |
| **Job Title/Job Code** | **Salary** | **FTE** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Total (Must reconcile with Schedule 4, Line 1)** |  |  |

**Direct Care – Instructional and Related Services - SCIS**

|  |  |  |
| --- | --- | --- |
| **Job Title/Job Code** | **Salary** | **FTE** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Total (Must reconcile with Schedule 4, Line 1)** |  |  |

Note: Nondirect and Direct Care Job Titles must conform to the chart at the beginning of Section 2: Budget Information

**Schedule 2: Projected Contracted Services - SCIS (other than personal services)**

In Schedule 2, provide information relating to contracts with individual consultants or other contractors expected during the year. The total amount should reconcile to Line 9, "Contracted Services," on Schedule 1 "Projected Program Expenditures."

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Contracted Service** | **Hours of Service** | **Total to be Paid**  **(Direct Care)** | **Total to be Paid (Nondirect Care)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Total (Must reconcile with Schedule 4, Line 9)** |  |  |  |

**Schedule 3: Projected Nondisabled Revenues (SCIS-only)**

If the applicant operates a Universal Prekindergarten (UPK), Head Start or private daycare program, then the applicant must report the total number of FTEs and amount of revenue expected to be collected for services the applicant will provide to students without disabilities by program using the chart below.

|  |  |  |
| --- | --- | --- |
| Program | Students Without Disabilities | |
|  | FTEs | Revenue |
| UPK |  |  |
| Head Start |  |  |
| Private |  |  |
| Total |  | $ |

1. **Special Classes (SC) –** Complete Schedules 1, 2 and 4 if the proposed change for the SC program affects the current certified tuition rate and meets the criteria for rate appeal.

**Section Not Applicable**

**Schedule 1: Projected Personal Services - SC**

**Nondirect Care – Administration/Facility - SC**

|  |  |  |
| --- | --- | --- |
| **Job Title/Job Code** | **Salary** | **FTE** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Total (Must reconcile with Schedule 4, Line 1)** |  |  |

**Direct Care – Instructional and Related Services – SC**

|  |  |  |
| --- | --- | --- |
| **Job Title/Job Code** | **Salary** | **FTE** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Total (Must reconcile with Schedule 4, Line 1)** |  |  |

Note: Nondirect and Direct Care Job Titles must conform to the chart at the beginning of Section 2: Budget Information

**Schedule 2: Projected Contracted Services - SC (other than personal services)**

In Schedule 2, provide information relating to contracts with individual consultants or other contractors expected during the year. The total amount should reconcile to Line 9, "Contracted Services," on Schedule 1 "Projected Program Expenditures."

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Contracted Service** | **Hours of Service** | **Total to be Paid**  **(Direct Care)** | **Total to be Paid (Nondirect Care)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Total (Must reconcile with Schedule 4, Line 9)** |  |  |  |

**Schedule 4: General Program Budget (SCIS and SC, as applicable)**

All applicants must complete Schedule 4 with costs related to the type of program proposed (i.e., SCIS and/or SC) if the proposed change for the SCIS and/or SC program affects the current certified tuition rate and meets the criteria for rate appeal.

| **Account** | **MDE** | | **SEIS** | | **SCIS** | | **SC** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Nondirect Care | Direct Care | Nondirect Care | Direct Care | Nondirect Care | Direct Care | Nondirect Care | Direct Care |
| **Personal Services:** | | | | | | | | |
| 1. Salaries |  |  |  |  |  |  |  |  |
| 2. Social Security |  |  |  |  |  |  |  |  |
| 3. Insurance (life and health) |  |  |  |  |  |  |  |  |
| 4. Pension and retirement |  |  |  |  |  |  |  |  |
| 5. Worker’s Compensation, Unemployment Insurance, NYS Disability |  |  |  |  |  |  |  |  |
| 6. Other Fringe Benefits (specify) |  |  |  |  |  |  |  |  |
| **7. Total Personal Services (Sum of Lines 1-6)** |  |  |  |  |  |  |  |  |
| **Other than Personal Services (OTPS):** | | | | | | | | |
| 8. Travel |  |  |  |  |  |  |  |  |
| 9. Contracted Services |  |  |  |  |  |  |  |  |
| 10. Supplies and Materials |  |  |  |  |  |  |  |  |
| 11. Repairs and Maintenance |  |  |  |  |  |  |  |  |
| 12. Staff Training |  |  |  |  |  |  |  |  |
| 13. Audit/Legal |  |  |  |  |  |  |  |  |
| 14. Office Supplies/ Postage |  |  |  |  |  |  |  |  |
| 15. Utilities/Phone |  |  |  |  |  |  |  |  |
| 16. Lease/Rental Vehicle |  |  |  |  |  |  |  |  |
| 17. Lease/Rental Equipment |  |  |  |  |  |  |  |  |
| 18. Depreciation – Vehicle |  |  |  |  |  |  |  |  |
| 19. Depreciation – Equipment |  |  |  |  |  |  |  |  |
| 20. Lease/Rental Property |  |  |  |  |  |  |  |  |
| 21. Leasehold and Leasehold Improvements |  |  |  |  |  |  |  |  |
| 22. Depreciation Building |  |  |  |  |  |  |  |  |
| 23. Depreciation – Building Improvements |  |  |  |  |  |  |  |  |
| 24. Depreciation – Land Improvements |  |  |  |  |  |  |  |  |
| 25. Interest – Mortgage |  |  |  |  |  |  |  |  |
| 26. Insurance – Property/Casualty |  |  |  |  |  |  |  |  |
| 27. BOCES Services (*Public School Use Only*) |  |  |  |  |  |  |  |  |
| 28. Other (Specify) |  |  |  |  |  |  |  |  |
| **29. Total OTPS (Sum of Lines 8-29)** |  |  |  |  |  |  |  |  |
| **30. GRAND TOTAL (Sum of Lines 7 and 29)** |  |  |  |  |  |  |  |  |

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| **Section 5: Character and Competence Review** |

**PUBLIC SCHOOL DISTRICTS, BOARDS OF COOPERATIVE EDUCATIONAL SERVICES, STATE AGENCIES OR MUNICIPALITIES ARE NOT REQUIRED TO COMPLETE THIS SECTION OF THE APPLICATION.**

**Complete only for changes in CEO or Chief School Officials and/or Owners**

**Copy and complete this section and accompanying affidavit form for each Owner/Chief Executive Officer/ and/or Chief Administrator or Executive Director who may fulfill the role and responsibilities of a Chief Executive/Administrator, or a portion of these duties.**

**Section Not Applicable**

|  |  |
| --- | --- |
| 1. Name of Chief Executive Officer/Owner/Administrator(s) | |
| 2. Primary Residence  City:       State: | |
| 3. Business Address | Street |
| City State       Zip |
| 4. Occupation | |
| 5. Educational History    **Attach résumé** | |
| 6. Certification(s)/License(s)    **Attach copies of certification(s)/license(s)**  Were your certificates/licenses ever refused?  Yes  No  Were your certificates/licenses ever revoked?  Yes  No  Were your certificates/licenses ever subject to other disciplinary action?  Yes  No  If yes, describe: | |
| 1. Community and philanthropic experience | |
| 1. Years of experience in the field of human services | |
| 1. Years of experience in a supervisory or management capacity | |
| 1. Indicate if you hold any other positions of employment     Yes  No  If yes, indicate the name of the employer, the job title, job responsibilities and the number of hours employed per week at the external position. | |
| 1. Identify any current and previous association(s) with a human services agency or vendor.   Specify the positions held (e.g., employee, owner, executive director, member of the board of directors). | |
| 1. Indicate if you have been employed by or have been a board member of an agency that has been cited for findings of waste, fraud, abuse, or wrongdoing, including but not limited to the unlawful acquisition, use, payment or expenditure of agency or program funds.   Yes  No  If yes, indicate which agency and in what capacity you were associated with the agency during the time of these findings. | |
| 1. Have you had affiliations with any program whose approval was revoked or suspended by NYSED or another State or federal agency?   Yes  No  If yes:  Provide the name of the program(s) and State oversight agency(ies):    Indicate what your affiliation was to the program: | |
| 1. Have you had affiliations with any program or entity that has been subject to past, current or pending disciplinary action, disallowance, fine or other penalty by NYSED or another State or federal agency?   Yes  No  If yes:  Provide the name of the program(s) and State oversight agency(ies):    Indicate what your affiliation was to the program: | |
| 1. Have you ever been convicted of a crime by a federal or State court in any jurisdiction?   Yes  No  If yes:  What was the criminal offense(s):    Was the criminal offense(s) a misdemeanor or felony? | |
| 1. Do you currently have any criminal charge(s) pending against you in a federal or State court in any jurisdiction?   Yes  No If yes, provide an explanation: | |
| 1. Affidavit:   I,      **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**, declare that, to the best of my knowledge, the information above is true, correct and complete.  Signature: Date:  Acknowledgment of Individual  STATE OF NEW YORK  COUNTY OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  On the \_\_\_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the year \_\_\_\_\_\_\_\_\_\_ before me, the undersigned, personally appeared \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity (ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.  Notary Public Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Notary Public Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_  My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **Section 6: Governance and Internal Controls** |

**Required only for changes in ownership**

The governance structure for for-profit entities is prescribed by the Business Corporation Law, Limited Liability Company Law or Partnership Law, as applicable.

Various provisions of the Education Law, Not-for-Profit Corporation Law and General Municipal Law impose legal duties, fiduciary responsibilities and fiscal requirements upon The University of the State of New York institutions and the trustees/board members who run them.

For purposes of this application section, governance for a program meansa combination of individuals filling executive and management roles, program oversight functions organized into structures, and policies that define management principles and decision making.

**PUBLIC SCHOOL DISTRICTS, BOARDS OF COOPERATIVE EDUCATIONAL SERVICES, STATE AGENCIES OR MUNICIPALITIES ARE NOT REQUIRED TO COMPLETE THIS SECTION OF THE APPLICATION.**

**Section Not Applicable**

**Narrative Information**

The agency’s owners or founding group/prospective Board of Trustees are required to read the most current version of the NYSED Reimbursable Cost Manual “Statement on the Governance Role of a Trustee or Board Member.” An agency whose governance structure does not contain a Board of Trustees or Board Members must adhere to the governance and oversight principles to the greatest extent practicable and should describe, in the answers below, how its proposed governance structure will fulfill similar oversight responsibilities in order to ensure proper administration and accountability of the agency.

|  |
| --- |
| 1. Describe the governance structure, as applicable, of the proposed program. |
| 1. Explain the procedures to be followed in instances where an individual’s personal or business interests may be advanced by an action of the governing structure of the agency. |
| 1. Explain the agency’s policy that would prohibit impermissible nepotism in hiring and other institutional business. |
| 1. Disclose any and all at-arms-length relationships as well as any affiliations/relationships with other entities that accept public funds including, but not limited to, Early Intervention providers, agencies providing related services and school-aged private schools. |
| 1. Describe the role of the individuals filling executive and management roles, and as applicable individuals with ownership interest, in establishing policies that define management principles and decision making. |
| 1. Provide a description of how periodic operating financial reviews and reports will be submitted and reviewed by the agency’s governing structure, including how the agency’s governing structure will perform a review of all claims and ensure proper itemization and documentation necessary for the approval of the agency’s expenditures. If the governing structure delegates this function to an individual(s) holding an executive or management role, the description outlines the format and frequency of reports that will be made directly to the agency’s board or owners. In the case of an agency that is structured as a sole proprietorship, this review function must be performed by an individual separate from the sole proprietor.     State the relationship the reviewer has with the agency. |
| 1. Provide evidence that individuals filling executive and management roles reside within a geographic region in proximity to the proposed program(s) to ensure appropriate and timely on-site oversight of the program. |
| 1. *Provide a description of the internal controls that will be established to ensure that the program is operating effectively and efficiently in all program and fiscal matters. Include information on internal controls relating to each of the following:*    1. *Ensuring a quality control environment:*    2. *Performing a risk assessment:*    3. *Designing effective policies and procedures:*    4. *Providing clear communication throughout the school/agency:*    5. *Conducting ongoing monitoring of policies and procedures:* |
| 1. The Code of Ethics must as a minimum include a Conflict of Interest policy, a policy outlining the procedure for reporting fraud, waste and abuse, and a whistleblower policy protecting employees from retaliation for disclosing information concerning acts of wrongdoing, misconduct, malfeasance or other inappropriate behavior.   **Attach a copy of the agency’s Code of Ethics.** |

1. The program must conduct at least 12 fire drills during the school year, eight of which must be held between September 1 and December 1 of each school year. A fire drill log, specifying time conducted, evacuation time and any difficulties encountered during the fire drill will be maintained. For programs operating on a 12-month basis, an additional two fire drills are required to be conducted during the months of July and August. [↑](#footnote-ref-1)
2. If applicant is proposing an expansion of its MDE program to additional geographic regions, it must first provide the SEQA Regional Associate with documentation that there is demonstrated need for the expansion of preschool services in the geographic region of the State in which the program is located. Information regarding the determination of regional need can be found at <http://www.nysed.gov/special-education/documentation-preschool-regional-need>. If regional need is confirmed, the Regional Associate will complete and provide to the applicant a *Determination of Regional Need* form which must be attached to this application. [↑](#footnote-ref-2)
3. See Footnote 2 [↑](#footnote-ref-3)
4. Note: The ratio of students with disabilities to students without disabilities should be generally equal. [↑](#footnote-ref-4)
5. All approved SCIS programs must provide, either directly or through contract, all of the related services in the students’ IEPs as a component of the SCIS program and within the instructional day. [↑](#footnote-ref-5)
6. The maximum class sizes must be consistent with section 200.6(h)(4) of the Regulations of the Commissioner of Education and be proposed as one or more of the following: 12 students to one teacher (plus additional staff); 8 students to one teacher (plus additional staff); 6 students to one teacher (plus additional staff). No other class size options will be considered (e.g., 7 students to one teacher plus additional staff). [↑](#footnote-ref-6)
7. All approved SC programs must provide, either directly or through contract, all of the related services in the students’ IEPs as a component of the student’s SC program and within the instructional day. [↑](#footnote-ref-7)