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**School-Age Approved Private School**

**Modification Request Application**

**For New York State Education Department Approval**

**to Expand and/or Modify an Existing Approved**

**Private School for Students with Disabilities**

**In-State or Out-of-State**

***Day/Residential Program***

**November 2013**

**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**

[**https://www.nysed.gov/special-education**](https://www.nysed.gov/special-education) **Table of Contents**

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**Modification Application for School-Age**

**Approved Private Schools**

**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**

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| **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 Submission Requirements 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 enrollment and/or changes to geographic region where the program will be located must first provide the Special Education Quality Assurance (SEQA) Regional Office with documentation that there is demonstrated need for the expansion. A Determination of Regional Need form **must be attached** to this application. For further information see <http://www.nysed.gov/special-education/school-age-applications>.

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| **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. 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 not applicable items as “N/A”.**

**The New York State Education Department (NYSED) will only initiate an application review if all required components of the application are completed and the required documentation is provided.**

**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.**

**Applicants may wish to review the Evaluation Criteria for each section of the application to determine if responses meet NYSED’s standard for acceptance at** [**http://www.nysed.gov/common/nysed/files/programs/special-education/school-age-modification-evaluationcriteria-july-2020.pdf**](http://www.nysed.gov/common/nysed/files/programs/special-education/school-age-modification-evaluationcriteria-july-2020.pdf)**.**

**Please submit as MS word or PDF document to:** [**OSEAPPLICATIONS@NYSED.gov**](mailto:OSEAPPLICATIONS@NYSED.gov)**.**

* 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 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 the original and one copy of the completed application and supporting documents to:

**New York State Education Department**

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

**Attention: Modification Application for Private School-Age Programs**

**89 Washington Avenue, Room 309 EB**

**Albany, NY 12234**

*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 at (518) 473-6108.

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

* It is NYSED’s intent to process Modification Applications for Private School-Age Programs within 45 calendar days of the receipt of complete application materials.
* Applicants may not implement the proposed modification request until written notification of approval by NYSED has been received.

**School-Age Approved Private School**

**Modification Request Application**

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**to Expand and/or Modify an Existing Approved**

**Private School for Students with Disabilities**

**In-State or Out-of-State**

***Day/Residential 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:** |  |

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

**NAME OF APPROVED PRIVATE SCHOOL:**

I hereby certify that I will comply with the requirements of Article 89 of the New York State (NYS) Education Law and Parts 200 and 201 of the Regulations of the Commissioner of Education and understand the program and fiscal requirements for operating an approved private school for students with disabilities.

The applicant also make(s) the following assurances pursuant to the Individuals with Disabilities Education Act (IDEA), Article 89 of the Education Law and Parts 200 and 201 of the Regulations of the Commissioner of Education:

* Parents of students will 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 NYS procedures.
* Instructional materials to be used in the program will be available in a usable alternative format, which meets the National Instructional Materials Accessibility Standard, for each student with a disability in accordance with the student’s individualized education program (IEP).
* The program will 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 student served with all of the special programs and services recommended in the student’s IEP at the recommended frequency, duration, and location.
* The program will cooperate with the school district, NYSED and other State oversight agencies in monitoring for compliance, effectiveness and fiscal integrity of the program.
* The program will provide data, records and reports to the referring school district, NYSED, 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 and will submit building plans and specifications to fire and local law enforcement officials to ensure rapid access to the school(s) in the event of an emergency.
* The program will comply with NYSED’s policies and procedures pertaining to the administration of medications to students.
* All special education instructional and extracurricular programs and services will be provided in nonsectarian, neutral settings.
* All board members and owners of private for-profit and not-for-profit agencies will complete NYSED training regarding their legal, fiduciary and ethical responsibilities within the first year of obtaining their role 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, will complete annual on-line CFR training as required by NYSED.
* No student with a disability will 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 will 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 proposed program 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 effective manner and shall operate in conformance with the requirements of the Reimbursable Cost Manual of NYSED.

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

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| --- |
| **School-Age Modification Application – Submission Requirements** |

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

|  |  |  |
| --- | --- | --- |
| ***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 9-16** | **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 location, new facility or building/classroom not previously used * Removing a previously approved site |  |
| **Section 3:**  **Program Operation Modification(s)** | **Required only for** proposed changes to Program Operation   * Class Size * Hours of Operation * 10-month/12-month program calendar * Population to be Served * Number of Classes (Reduction or Expansion) * Addition or deletion of Related Services provided * Change in Day/Residential status |  |
| **Section 4:**  **Staffing** | **Required only for** proposed changes to Location/Site Information and/or Program Operation Modifications which require changes in Staffing numbers or types |  |
| **Section 5:**  **Program Budget** | **Required only for** proposed changes that affect the current certified tuition rate(s) and meet the criteria for rate appeals (e.g., class ratios, enrollment, staffing, added locations) |  |
| **Section 6:**  **Character and Competence** | **Required only for** change in the Chief Executive Officers/Chief School Officials/Owners |  |
| **Section 7:**  **Governance** | **Required only for** change to the ownership of the provider agency |  |
|  | | |

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| **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 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. | For Residential School Applicants: Contact person for the State agency(ies) that license or certify the residential component. | State Agency  Name of Contact Person | | | | | |
| Title | | | | | |
| Telephone | Fax Number | | | Email Address | |
| 15 | For Out-of-State Applicants: Contact person for the state educational agency (SEA) in the state where the school is located. | State Educational Agency  Name of Contact Person | | | | | |
| Title | | | | | |
| Telephone | | Fax Number | Email Address | |
| 16 | Private Entity  Indicate whether this is a domestic or foreign 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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Domestic  Foreign | | | | |
| Nonprofit | Regents Charter  Education Corporation (Regents Certificate of Incorporation)  Other not-for-profit corporation or organization | | | | |

**If there are any changes to items 14 and/or 16, 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).

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| **Section 2: Site Information** |

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

If any part of this modification involves construction or renovation, you cannot begin until you receive all necessary written approvals. See [http://www.oms.nysed.gov/rsu/Manuals\_Forms/Manuals/  
CapitalProjects/home.html](http://www.oms.nysed.gov/rsu/Manuals_Forms/Manuals/CapitalProjects/home.html) for further information on requirements for Capital Construction Project approval. (Only those capital construction projects resulting in changes to or added sites or classrooms require a modification application.)

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| Describe the proposed modification and provide a narrative rationale for the proposed change. |

***Complete only for those sites to be added, deleted and/or when there is a change to contact information.*** For each program site listed below, attach copies of Building Lease(s) or Amortization Schedule(s) (as appropriate).

**Site 1 attached**

**Site 2 attached  NA**

**Site 3 attached  NA**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Site 1**  please check if there is no prior approval for any school-age 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** | | | |
| **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)  Instructional space  Other, specify  **Is this building used for any other purpose or by any other entity?**  No  Yes (specify): | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Site 2**  please check if there is no prior approval for any school-age 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** | | | |
| **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)  Instructional space  Other, specify  **Is this building used for any other purpose or by any other entity?**  No  Yes (specify): | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Site 3**  please check if there is no prior approval for any school-age 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** | | | |
| **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)  Instructional space  Other, specify  **Is this building used for any other purpose or by any other entity?**  No  Yes (specify): | | | |

**A. Health and Safety Compliance**

***Complete only for proposed additional sites:***

|  |  |
| --- | --- |
| **Documentation Required** | **Attached** |
| 1. Certificate of Occupancy | Site 1:  Site 2:  NA:  Site 3:  NA: |
| 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:  NA:  Site 3:  NA: |
| 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:  NA:  Site 3:  NA: |
| 4. Fire/Disaster Evacuation Plan including procedures to evacuate nonambulatory individuals. (For additional information, see [http://www.p12.nysed.gov/facplan/ articles/EmergencyEvacuation2.htm](http://www.p12.nysed.gov/facplan/articles/EmergencyEvacuation2.htm)) | Site 1:  Site 2:  NA:  Site 3:  NA: |
| 5. Is the building used for instructional purposes in the summer? | No attachment needed.  **Yes No NA**  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**

***Complete only for proposed additional sites.***

| **Documentation Required** | **Attached** | | |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **NA** |
| 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. 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 operation of the approved private school program:   * 4410 preschool program * 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**

***Complete only for proposed additional sites.***

| **Documentation Required** |  | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
|  | | **Yes** | | **No** | **NA** |
| 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/N/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. |  |  | |  | |  |

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

**A. Program Types**

***Specify the program type for which you are applying for modification approval.***

|  |  |  |
| --- | --- | --- |
| **Program Types** | **Requesting Approval** | **Program Calendar** |
| Day School | Yes  No | 10-month (September – June)  12-month (July – June) |
| Residential School | Yes  In-State  Out-of-State  No | 10-month (September – June)  12-month (July – June) |

**B. Description of Program Modification**

***Complete each section as applicable to the proposed modification.***

|  |
| --- |
| Describe the proposed modification and provide a narrative rationale for the proposed change(s): |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Population to be served:   Disability categories to be served in the program (check those that apply):   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Disability Category** | **Current** | **Proposed** | **Disability Category** | **Current** | **Proposed** | | Autism |  |  | Multiple Disabilities |  |  | | Deafness |  |  | Orthopedic Impairment |  |  | | Deaf-Blindness |  |  | Other Health Impairment |  |  | | Emotional Disability |  |  | Speech or Language Impairment |  |  | | Hearing Impairment |  |  | Traumatic Brain Injury |  |  | | Intellectual Disability |  |  | Visual Impairment  (including blindness) |  |  | | Learning Disability |  |  |  |  |  |   Ages: Current:       Proposed:  Enrollment capacity[[2]](#footnote-2): Current:       Proposed:  Student Management Needs:  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. |
| 1. Changes to total number of special classes proposed:   Current:       Proposed: |
| 1. For each special class, indicate the maximum class size[[3]](#footnote-3), age range of the students, instructional levels and the number of teachers, teaching assistants, teacher aides and other professionals assigned to each class.  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | **Class 1** | **Class 2** | **Class 3** | **Class 4** | **Class 5** | | Maximum Class Size |  |  |  |  |  | | Age Range of Students |  |  |  |  |  | | Instructional Levels |  |  |  |  |  | | Number of Certified Special Education Teachers |  |  |  |  |  | | Number of Certified Teaching Assistants |  |  |  |  |  | | Number of Teacher Aides |  |  |  |  |  | | Other Professionals  Assigned to Each Class  (List Separately) |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |
| 1. Proposed changes to the related services to be provided to meet the IEPs of students enrolled in the program:     Identify the type of service(s):    Projected caseloads (numbers only) of related services providers: |
| 1. Program Schedule   Attach a sample daily schedule of instructional activities from arrival to dismissal. Note that each school day must provide not less than 5 hours of instruction at the elementary level and 5 1/2 hours of instruction at the middle/secondary level, including related services, but excluding transportation and lunch.  Provide the proposed total number of instructional hours per day for the program:      Identify the specific times when instruction will occur:   |  | **Morning**  **Instructional Time** | | **Afternoon**  **Instructional Time** | | | --- | --- | --- | --- | --- | | **Start** | **Finish** | **Start** | **Finish** | | Monday |  |  |  |  | | Tuesday |  |  |  |  | | Wednesday |  |  |  |  | | Thursday |  |  |  |  | | Friday |  |  |  |  |   Notations: (optional)  Attach operational (school year) calendar |

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| **Section 4: Staffing** |

All applicants must provide narrative responses for questions 1-3 and complete the Program Staffing Summary table.

|  |
| --- |
| 1. Describe the proposed staffing plan for the program: |
| 1. Describe how the proposed staffing will meet the needs of the students to be served without reliance on one-to-one aides: |
| 1. Describe how the proposed staffing will ensure appropriately qualified individuals will be available to provide instruction to students during staff absences (i.e., substitutes): |

**Complete Program Staffing Summary** (copy and attach additional sheets as needed)

| **Personnel Name** | **Job Title** | **Type of NYS Certification or License held, if applicable**  **🞏 Attach copies** | **Certificate/License and NPI Number, if applicable**  **🞏 Attach copies** | **Hours Per Week for Administrative Duties** | **Specify Staff (S), Contract (C) or per diem (P)** | **Hours Per Week for School-age program** | **Hours per Week for Other Programs within this Agency** | **Total Hours Per Week (not to exceed 40)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **IN ADMINISTRATIVE TITLES:** |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **IN TEACHING TITLES:** |  |  |  |  |  |  |  |  |
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| **IN SUPPLEMENTARY SCHOOL PERSONNEL TITLES:** |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |
| **IN RELATED SERVICE TITLES:** |  |  |  |  |  |  |  |  |
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| **OTHER:** |  |  |  |  |  |  |  |  |
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**Note: Any staff person functioning as a supervisor for more than 25 percent of his or her scheduled time must hold an appropriate administrative certification.**

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| --- |
| Section 5: Budget Information |

***Completion******of Section 5 is required only as applicable to proposed modifications that would affect the current certified tuition rates and meet the criteria for rate appeals pursuant to section 200.9(f)(3)(i).***

**Projected Personal Services – General Information for completing Schedule 1**

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](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 3 "General Program Budget."

**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 |  |
| Administrator | Teaching Assistant, Teacher Aide – Students with Disabilities |
| Accountant/Bookkeeper |  |
| 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 |

Complete Schedules 1-3

**Schedule 1: Projected Personal Services**

**Nondirect Care – Administration/Facility**

|  |  |  |
| --- | --- | --- |
| **Job Title/Job Code** | **Salary** | **FTE** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Total (Must reconcile with Schedule 3, Line 1)** |  |  |

**Direct Care – Instructional and Related Services**

|  |  |  |
| --- | --- | --- |
| **Job Title/Job Code** | **Salary** | **FTE** |
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|  |  |  |
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| **Total (Must reconcile with Schedule 3, Line 1)** |  |  |

Note: Nondirect and Direct Care Job Titles must conform to the chart at the beginning of Section 5: Budget Information.

**Schedule 2: Projected Contracted Services (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 3 "General Program Budget."

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Contracted Service** | **Hours of Service** | **Total to be Paid**  **(Direct Care)** | **Total to be Paid (Nondirect Care)** |
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| **Total (Must reconcile with Schedule 3, Line 9)** |  |  |  |

**Schedule 3: General Program Budget**

| **Account** | **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. Other (Specify) |  |  |
| **28. Total OTPS (Sum of Lines 8-27)** |  |  |
| **29. GRAND TOTAL (Sum of Lines 7 and 28)** |  |  |

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| **Section 6: Character and Competence Review** |

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.

|  |  |
| --- | --- |
| 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  revoked?  Yes  No  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  Printed Name:  My Commission Expires: | |

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| **Section 7: Governance and Internal Controls** |

*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 means**a combination of individuals filling executive and management roles, program oversight functions organized into structures, and policies that define management principles and decision making.*

**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” and complete this section. An agency whose governance structure does not contain a Board of Trustees or Board Members must read the “Statement on the Governance Role of a Trustee or Board Member” and 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-arm’s-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 approved preschool programs. |
| 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 a narrative description showing that individuals filling executive and management roles reside within a geographic region in reasonable proximity to the 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. Attach a copy of the agency’s Code of Ethics.   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. |

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. Programs must provide instruction to a minimum of 16 NYS publically placed students with disabilities. [↑](#footnote-ref-2)
3. 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-3)