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

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

APPLICATION FOR TUITION ASSISTANCE PROGRAM FOR DEAF INFANTS

Infant's Name: _____ (Last) _____ (First) Sex: ☐ F ☐ M

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

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

STATEMENT OF PARENT OR LEGAL GUARDIAN

I, the parent or legal guardian of the above-named infant, hereby apply for admission for my deaf infant to the deaf infant program at (fill in name of approved agency) _____ and for State assistance for the approved educational program. I hereby grant permission for the release to the State Education Department of necessary docume

Signature: _____ Date _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

County: _____ Telephone Number: _____

☐ Yes ☐ No