THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12

OFFICE OF SPECIAL EDUCATION
SPECIAL EDUCATION QUALITY ASSURANCE
NONDISTRICT UNIT
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Telephone: (518) 473-3185
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APPLICATION FOR TUITION ASSISTANCE PROGRAM FOR DEAF INFANTS

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

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

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: _____

, V W K L V W K H F K L O G ¶ V S U L P D U ☐ Yes ☐ No

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