

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT

Charter School Request for State Aid Intercept

Name of Charter School _____

Address _____

Telephone _____ Fax _____

Principal/Director: _____

Name/Title of Person Submitting Request: _____

Signature of Person Submitting Request: _____

Directions:

1. Please provide all information requested. Do not omit any information as it will significantly delay the Department's ability to process your request. Requests for the intercept of State aid will not be processed until all required information has been submitted.
2. A separate spreadsheet must be completed for each district against which you are making a claim.
3. Do not make claims for a State aid intercept unless the district in question is more than 30 days in arrears.
4. For all students, you must provide the following information:
 - Student name
 - Entry date (i.e., the date on which the student began classes at the charter school during the school year in question)
 - Withdrawal date from the charter school, if applicable
 - The student's FTE count (use the FTE calculator on the Department's State Aid webpage at <http://stateaid.nysed.gov/calcFTE.htm>)
5. For students receiving special education, in addition to the above, you must also provide the following information:
 - Level of service (e.g., consultant teacher only, < 20%, 20%, 60%)
 - Placement (e.g., inclusion, resource room)
6. Please also provide evidence (e.g., copies of letters to/from the district in question) of the charter school seeking payment and, if applicable, the district's refusal to pay.
7. You should refer to Section 2856 of the Education Law and Part 119.1 of Commissioner's Regulations for additional information regarding the financing of charter schools.
8. Submit an original and one copy to:

Public School Choice Programs
New York State Education Department
Room 462 EBA
Albany, New York 12234

FOR DEPARTMENT USE ONLY

Rec. by PSCP: _____ Initials: _____

Check if Incomplete: _____ All data received: _____

Sent to OSA: _____ Received by OSA: _____

"Enter District Code"	"Enter District Name"						
REGULAR FTE							
Period Covered	Total FTE Enrollments	Final Adj. Expense/ Pupil (2002-03)	District Aid	Expected Payments	District Payments	Cumulative Amount Owed	Outstanding Balance
July/August		"From State Aid"					
September/October							
November/December							
January/February							
March/April							
May/June							
TOTAL				0.00	0.00		0.00
SPECIAL EDUCATION FTE							
Period Covered	Resident WTD Excess Cost Pupil	Estimated Annualized Costs (\$)	Total Excess Cost Aid	Expected Payments	District Payments	Cumulative Amount Owed/Period	Outstanding Balance
July/August							
September/October							
November/December							
January/February							
March/April							
May/June							
Projected Annual Excess Cost Aid				0.00	0.00		0.00
Total District Aid		\$0.00					
Total District Payments		\$0.00					
Overall Balance		\$0.00					