City School District of Albany
Supplemental Educational Services Selective Form

The student listed below is eligible to participate in Supplemental Educational Services. The child's parent has reviewed and selected a NYS approved SES provider. The SES provider must provide information in the two boxes; check the assurances, sign and date. The parents will then sign and date to indicate their agreement with the instructional program outlined by the provider.

Student name/Student ID) Number______________________

School/Grade: ______________________________________

Name of Provider: **St. Johns CDC**
Address/Contact: **94 Herkimer Street**
Albany, NY 12202
www.stjohnscdc.org
info@stjohnscdc.org
(518)462-0886

Parent/Guardian: __________________________

Address/Contact:
____
____
____
Phone:___________________________________

SES Provider: List below the specific achievement goals for the student, as developed in consultation with the student's parent/guardian, that include a timetable for improving the student's achievement: [Section 1116(e) (3) (A)/

Read Naturally will be used as the learning tool to enhance the student's reading skills. The student will receive one on one tutoring n addition to working independently. The focus will be placed on comprehension, vocabulary and mastering learning. The goal is to build fluency and confidence in these areas of reading comprehension, fluency, retention, and expression.

SES Provider: Describe how the student's progress will be measured and how the student's parent/guardian and teacher will be regularly informed of that progress. [Section 1116 (e) (3) (A) and (B)]

Read Naturally will be used, and a pre-test will be administered and 60 days later a part test. Parents and teachers will be informed of progress.

The SES provider understands and agrees to the following: (Check for affirmation)

- **The services will be provided consistent with applicable health, safety, and civil rights laws**
- **The provider is prohibited from disclosing to the public the identity of any student eligible for or receiving supplemental educational services without the written permission of the student's parent/guardian**
- **The payment for SES will be invoiced quarterly at the rate set by the service provider or not more than the maximum allowable per pupil rate for the current school year**
- **The agreement will be terminated if the SES provider fails to meet student progress goals and timetables**

Principal: ______________________________Date: ______
(Printed names/signature)

SES Provider: __________________________Date _______
(Printed names/signature)

Parent/Guardian: ________________________Date:______
(Printed names/signature)

District Representative: _______________________ Date: ______
(Printed names/signature)

Note: The District is not responsible for any SES program costs beyond the officially approved starting and ending date.