

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**SCHOOL DISTRICT NOTIFICATION OF FINANCIAL RESPONSIBILITY  
FOR EDUCATIONALLY DISABLED FOSTER CHILD  
PLACED IN A CHILD CARE INSTITUTION**

① **TO:**  
  
*(School district of origin)*

② **FROM:**  
  
*(Local department of social services)*

Pursuant to the provisions of Section 4006 of the Education Law, I am notifying you of your financial responsibility for the placement of the below named child in a child care institution or residential treatment facility.

③  New LDSS-3424

④  Correction(s) to a previous LDSS-3424

⑤ \_\_\_\_\_  
WMS/CCRS CLIENT ID

⑥ \_\_\_\_\_  
Child ID (For office use only)

⑦ \_\_\_\_\_ CHILD'S LAST NAME      \_\_\_\_\_ FIRST      \_\_\_\_\_ MI      \_\_\_\_\_ DATE OF BIRTH (mm/dd/yy)       M  F SEX

⑧ **LEGISLATIVE AUTHORIZATION:**

CHAPTER 563 – CHILDCARE INSTITUTIONS      ⑨ CHILD'S RACIAL/ETHNIC CATEGORY \_\_\_\_\_ (See reverse side for codes)

CHAPTER 947 – RESIDENTIAL TREATMENT FACILITIES (RTF)      ⑩ CHILD'S PRIMARY HANDICAPPING CONDITION \_\_\_\_\_ (See reverse side for codes)

⑪ \_\_\_\_\_ PUBLIC SCHOOL DISTRICT CERTIFYING DISABLING CONDITION      \_\_\_\_\_ For Office use only

⑫ \_\_\_\_\_ CERTIFICATION DATE (mm/dd/yyyy)

⑬ \_\_\_\_\_ DATE OF ADMISSION TO CARE (Date of entry or re-entry to foster care, mm/dd/yyyy)

⑭ \_\_\_\_\_ DATE OF TERMINATION OF CARE (If known, mm/dd/yyyy)

⑮ \_\_\_\_\_ PUBLIC SCHOOL DISTRICT AT TIME OF ADMISSION TO CARE (At time of Entry or Re-entry to Foster Care)      \_\_\_\_\_ For office use only

⑯ \_\_\_\_\_ LEGISLATIVE AUTHORIZATION EFFECTIVE DATE (MONTH/DAY/YEAR) (Date placed in institution or RTF, mm/dd/yyyy)

⑰ \_\_\_\_\_ LEGISLATIVE AUTHORIZATION TERMINATION DATE (mm/dd/yyyy) (If known)

⑱ \_\_\_\_\_ NAME OF FACILITY IN WHICH CHILD RESIDES

⑲ \_\_\_\_\_ LDSS OR OTHER CARE AGENCY AT ADMISSION TO CARE      \_\_\_\_\_ For office use only

I CERTIFY THAT THIS CHILD HAS BEEN PLACED IN ACCORDANCE WITH THE LEGISLATIVE AUTHORIZATION INDICATED ABOVE:

⑳ SIGNATURE OF PERSON COMPLETEING THIS FORM: \_\_\_\_\_ TITLE: \_\_\_\_\_ DATE: / /

NAME OF AGENCY: \_\_\_\_\_ TELEPHONE NUMBER (AREA CODE): \_\_\_\_\_

## INSTRUCTIONS FOR COMPLETING THE LDSS-3424 FORM

- (1) **School district of origin** – The name and location of school district where child resided at time of entrance to foster care.
- (2) **Local department of social services** – The name and address of the local department of social services (ldss) that is responsible for the child.
- (3) **New LDSS-3424** – Check box if this is the initial form for this child.
- (4) **Correction(s) to a previous LDSS-3424** – check box if this form corrects a previous notification for this child (*e.g. incorrect dates or other data*).
- (5) **WMS/CCRS Client ID** – The number assigned the child by the WMS/CCRS system.
- (6) **Child ID** – (*Office Use Only*)
- (7) **Child's name, date of birth and sex** – The child's complete name, date of birth and sex.
- (8) **Legislative authorization** – (*Check appropriate box*) For a foster child placed in a child care institution or residential treatment facility.
- (9) **Child's Racial/Ethnic category** – Put the code which identifies, to the best of your knowledge, the racial/ethnic category (*definitions below*) the child most identifies with:
 

1	<b>American Indian or Alaskan Native</b> – A person having origins in any of the original peoples of North America, and whom maintains cultural identification through tribal affiliation or community recognition.
2	<b>Asian or Pacific Islander</b> – A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands and Samoa.
3	<b>Black</b> – A person having origins in any of the black racial groups of Africa.
4	<b>Hispanic</b> – A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.
5	<b>White</b> – A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.
- (10) **Child's Primary Handicapping Condition** – Put the code for the condition (*specified below*) of the child as classified by the Committee on Special Education:
 

<b>01</b> Autism Spectrum Disorder	<b>07</b> Speech Impaired
<b>02</b> Emotionally Disturbed	<b>08</b> Visually Impaired
<b>03</b> Learning Disabled	<b>09</b> Orthopedically Impaired
<b>04</b> Intellectual Disability	<b>10</b> Other Health Impaired
<b>05</b> Deaf	<b>11</b> Multiple Handicapped
<b>06</b> Hard of Hearing	
- (11) **Public school district certifying disability condition** – The local public-school district where the Committee on Special Education (CSE) classified the child (*coding boxes are for office use only*).
- (12) **Certification date** – The date of the child's handicapped classification.
- (13) **Date of admission to care** – The date the child most recently entered or re-entered foster care.
- (14) **Date of termination of care** – The date of discharge or case closing if applicable.
- (15) **Public school district at time of admission to care** – The name of the school district where child resided at time of most recent entry or re-entry to foster care (*coding boxes are for office use only*).
- (16) **Legislative authorization effective date** – The date of placement for the child in this facility.
- (17) **Legislative authorization termination date** – The date of discharge from facility or case closing if applicable.
- (18) **Name of facility in which child resides** – The name of the child care institution or RTF where the child is placed.
- (19) **LDSS district or other care agency at admission to care** – The name of the local department of social services or other agency that is responsible for the child (*coding boxes are for office use only*).
- (20) **Signature of person completing this form** – self-explanatory.

**Send one copy of the completed form to:**

New York State  
Office of Children and Family Services  
Attn: Bureau of Budget Management  
52 Washington Street, Rm. 314 South  
Rensselaer, NY 12144

**One copy to:** Local DSS (*Fiscal office, Case file*); **One copy to:** Facility/other agency where child is placed