Center on Disability and Community Inclusion ⦁ 208 Colchester Ave, Mann Hall, Burlington, VT 05405 ⦁ Phone: 802-656-4031

**VT CENSUS ELIGIBILITY FORM**

**for Children and Youth with Combined Vision and Hearing Loss or Deafblindness**

The ***VT Sensory Access Project*** (also known as the VT Deaflind Project) is a U.S. Department of Education federally funded project with the responsibility of identifying all children in VT who have, or are at risk of having, combined vision and hearing loss. Identification allows us to follow the educational progress of these children from early intervention through exiting school as a young adult. Every year, their families and other team members are offered the supports and resources of the Project that are designed to help address the need for sensory access.

A. **STUDENT INFORMATION** Only date of birth, gender and ethnicity are included in the VT Census Report to US Department of Education. No other personally identifying information is submitted.

**Student: Date of Birth:**

**MALE FEMALE**

**Race/Ethnicity** (Check Only One):

1. American Indian or Alaska Native 4. Hispanic/Latino 7. Two or more races

2. Asian 5. White

3. Black or African American 6. Native Hawaiian/Pacific Islander

**Address:**

**Parent/Guardian: Telephone:**

**Address** (If Other than Above)**:**

**Email:**

**School District: Year:**

**Contact Person/Case Manager: Phone:**

**Email:**

**B. PERSON COMPLETING FORM Date:**

**Name: Email:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agency/School: Address:**

**Relationship/Title: Phone:**

**C.** **PRIMARY IDENTIFIED ETIOLOGY** **Please indicate primary disability.**

Primary Disability:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**D. VISUAL IMPAIRMENT** **Please attach reports.** NOTE: Items 5 & 8 are intentionally not used or available.

|  |  |
| --- | --- |
| **Documented Vision Loss (**Please **Check One** Item From 1-9): | **Sources of Documentation:** |
| 1. Low Vision (Visual Acuity of 20/70 to 20/200 ***with correction***)  2. Legally Blind (Visual Acuity of 20/200 or Less or Field Restriction of 20 Degrees ***with correction)***  3. Light Perception Only  4. Totally Blind  5. XXX  6. Diagnosed Progressive Loss  7. Further Testing Needed (1 year only)  8. XXX  9. Documented Functional Vision Loss  **Does the child have Cortical Visual Impairment?**  Yes No Unknown | **Ophthalmologist:**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Most Recent Exam: \_\_\_\_\_\_\_\_\_\_  **Optometrist:**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Most Recent Exam: \_\_\_\_\_\_\_\_\_\_  **Functional Vision Assessment and/or CVI Assessment:**  Assessor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Most Recent Assessment: \_\_\_\_\_\_ |
|  |  |

**E. HEARING IMPAIRMENT** **Please attach reports.** NOTE: Item 8 is intentionally not used or available.

|  |  |
| --- | --- |
| **Documented Hearing Loss (**Please **Check One** Item From 1-9): | **Sources of Documentation:** |
| 1. Mild (26-40 dB Loss)  2. Moderate (41-55 dB Loss)  3. Moderately Severe (56-70 dB Loss)  4. Severe (71-90 dB Loss)  5. Profound (91+ dB Loss)  6. Diagnosed Progressive Loss  7. Further Testing Needed (1 year only)  8. XXX  9. Documented Functional Hearing Loss  **Does the child have Central Auditory Processing Disorder?**  Yes No Unknown  **Does the child have Auditory Neuropathy?**  Yes No Unknown  **Does the child have a Cochlear Implant?**  Yes No Unknown | **ENT/Physician:**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Most Recent Exam: \_\_\_\_\_\_\_\_\_\_  **Audiologist:**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Most Recent Exam: \_\_\_\_\_\_\_\_\_\_  **Functional Hearing Assessment:**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Most Recent Assessment: \_\_\_\_\_ |
|  |

**F. OTHER IMPAIRMENTS** Indicate additional impairments beyond hearing and visual impairments that have a significant impact on the individual’s developmental or educational progress. **Check all that apply.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Orthopedic/Physical Impairments | 0. No | 1. Yes | Cognitive Impairments | 0. No | 1. Yes |
| Behavioral Disorder | 0. No | 1. Yes | Complex Health Care Needs | 0. No | 1. Yes |
| Communication/Speech/Language Impairments | 0. No | 1. Yes |  | | |
| Other Impairment(s) | 0. No | 1. Yes | Specify: | | |

**G. Part C CATEGORY** For children **birth through 2**, please **check one** of the following:

|  |
| --- |
| At risk for developmental delays (as defined by the state’s Part C Lead Agency) |
| Developmentally Delayed |
| Not Reported under Part C |

**H. Part B CATEGORY** (This information must match district's Dec. 1st Child Count Report). For **school-age students, 3-21**, **please check one** of the following:

|  |  |
| --- | --- |
| **PAR 1** 1. Mental Retardation  2. Hearing Impairment (Includes Deafness)  3. Speech or Language Impairment  4. Visual Impairment (Includes Blindness)  5. Emotional Disturbance  6. Orthopedic Impairment  7. Other Health Impairment  8. Specific Learning Disability | 9. Deaf-Blindness  10. Multiple Disabilities  11. Autism  12. Traumatic Brain Injury  13. Developmentally Delayed- age 3 through 9  14. Non-Categorical  15. Not Reported Under Part B of IDEA |

**I. EDUCATIONAL SETTING check one** from the age category that matches child’s age

|  |  |  |
| --- | --- | --- |
| **Age: Birth through 2 (Early Intervention Settings)** | **Age: 3-5 (Early Childhood Special Education**  **Settings** | |
| 1. Home  2. Community-Based Setting  3. Other Setting | 1. Attends a Regular Early Childhood Program  at least 80% Time  2. Attends a Regular Early Childhood Program  at least 40% - 79% Time  3. Attends a Regular Early Childhood Program  less than 40% Time  4. Attending a Separate Class  5. Attending a Separate School  6. Attending a Residential Facility  7. Service Provider Location  8. Home | |
| **Age: 6-12 (Educational Settings)** | | |
| 9. Attends Regular Class At Least 80% Time | | 13. Residential Facility |
| 10. Attends Regular Class At Least 40% - 79% of time  11. Attends Regular Class Less than 40%Time | | 14. Homebound/Hospital  15. Correctional Facility |
| 12. Separate School | | 16. Parentally placed in private schools |
|  | |  |

**J. PARTICIPATION IN STATEWIDE ASSESSEMENTS**

|  |  |
| --- | --- |
| 1. Regular Grade-Level State Assessment  2. Regular Grade-Level State Assessment with  Accommodations  3. Alternate Assessments Aligned with Grade-Level  Achievement Standards | 4. Alternate Assessments Based on Alternate  Achievement Standards  5. Modified Achievement Standards  6. Not Required at Age or Grade Level |

**K. LIVING SETTINGS**

|  |  |
| --- | --- |
| 1. Home: With parents  2. Home: Extended family  3. Home: Foster parents  4. State Residential Facility  5. Private Residential Facility  6. Group Home (Less than 6 Residents) | 7. Group Home (6 or more Residents)  8. Apartment (with Non-Family Person (s)  9. Pediatric Nursing Home  10. Other. (Please Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**L. CORRECTIVE LENSES**

|  |
| --- |
| Please indicate whether the child/student wears glasses or contact lenses. |
| 0. No 1. Yes 2. Unknown |

**M. ASSISTIVE LISTENING DEVICES**

|  |
| --- |
| Please indicate whether the child/student wears hearing aids or uses an FM system or other assistive listening device. |
| 0. No 1. Yes 2. Unknown |

**N. ADDITIONAL ASSISTIVE TECHNOLOGY**

|  |
| --- |
| Please indicate whether the child/student uses any additional assistive technology other than corrective lenses or or assistive listening devices. |
| 0. No 1. Yes 2. Unknown |

**O. VERMONT'S ELIGIBILITY CODE** Please check **ONE** of the following that matches the disability category reported for this child on the IEP.

|  |  |
| --- | --- |
| 01. Learning Impairment | 07. Other Health Impairment |
| 02. Specific Learning Disability | 08. Emotional Disturbance |
| 03. Visually Impairment | 09. Autism Spectrum Disorders |
| 04. Deaf or Hard of Hearing | 10. Traumatic Brain Injury |
| 05. Speech or Language Impairment | 11. Deaf-blindness |
| 06. Orthopedic Impairment | 12. Multiple Disabilities |

**P. STATUS DETERMINATION** This Information is Not Included in the Census Report to US Dept. of Education.

It is our opinion that, , meets the eligibility criteria for:

Student's Name

**Check one:**

**COMBINED VISION AND HEARING LOSS OR DEAF-BLINDNESS**

*Dual Sensory Impairment (Deaf-Blindness)* is a simultaneous impairment of auditory and visual functioning. This combination can cause severe communication, developmental, and educational problems for the child.

**AT RISK FOR COMBINED VISION AND HEARING LOSS OR DEAF-BLINDNESS**

Students *at risk for Dual Sensory Impairment (Deaf-blindness)* may show inconsistent or inconclusive responses during clinical hearing and/or vision evaluation, inconsistent responses to auditory and/or visual stimuli in the environment, or a chronic or degenerative health impairment associated with, or resulting in, Deaf-Blindness or dual sensory impairment.

**\*Please attach reports of clinical evaluations supporting the team's recommendation.\***

**Signatures of Team Members** (minimum of 3 including parent):

Name Position Date

1)

2)

3)

4)

If at any time, team members feel that this child/youth no longer meets the eligibility as dual sensory impaired or deafblind, please contact:

Emma Nelson, MS, Ed., VSAP Director

VT Sensory Access Project

Center on Disability & Community Inclusion

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