

2019 Deaf-Blind Child Count Reporting Form – for submission 2020

Complete and return to: Mary Anne Clendenin or Ruth Ann King, Building 6, Room 248, 1900 Kanawha Boulevard E., Charleston, WV 26505

If you have questions please contact Mary Anne Clendenin and Ruth Ann King at 304-558-2696 or raking@k12.wv.us

Complete this form ONLY for individuals who have both a visual and auditory impairment. DO NOT USE for an individual with only a visual impairment or only a hearing impairment.

Today's Date:

Part I: Information about individual with deaf-blindness

Name First: _____ Last: _____

Date of Birth (MM/DD/YYYY) / / **Gender:** __ Male __ Female

Race/Ethnicity (Select the ONE that best describes the individual's race/ethnicity):

- | | |
|--|--|
| <input type="radio"/> 1 American Indian or Alaska Native | <input type="radio"/> 5 White |
| <input type="radio"/> 2 Asian | <input type="radio"/> 6 Native Hawaiian/Pacific Islander |
| <input type="radio"/> 3 Black of African American | <input type="radio"/> 7 Two or more races |
| <input type="radio"/> 4 Hispanic/Latino | |

Living Setting (Select the ONE setting that best describes where the individual resides the majority of the year): O

- | | | |
|--|---|--|
| <input type="radio"/> 1 Home: Birth/Adoptive Parents | <input type="radio"/> 5 Private Residential Facility | <input type="radio"/> 9 Pediatric Nursing Home |
| <input type="radio"/> 2 Home: Extended Family | <input type="radio"/> 6 Group Home (less than 6 residents) | <input type="radio"/> 555 Other: |
| <input type="radio"/> 3 Home: Foster Parents | <input type="radio"/> 7 Group Home (6 or more residents) | |
| <input type="radio"/> 4 State Residential Facility | <input type="radio"/> 8 Apartment (with non-family members) | |

Parent/Guardian Name 1 First: _____ Last: _____

Street:

City: _____ State: _____ ZIP Code _____

Telephone (With Area Code) _____ Email: _____

Parent/Guardian Name 2 First: _____ Last: _____

Street:

City: _____ State: _____ ZIP Code _____

Telephone (With Area Code) _____ Email: _____

Part II: Individual's Medical Background/Disabilities

Primary Classification of Visual Impairment (Select the ONE that best describes the primary classification of the individual's visual impairment):

- | | |
|---|---|
| <input type="radio"/> 1 Low Vision (visual acuity of 20/70 to 20/200>) | <input type="radio"/> 6 Diagnosed Progressive Loss |
| <input type="radio"/> 2 Legally Blind (visual acuity of 20/200 or less, or field restriction of 20 degrees) | <input type="radio"/> 7 Further Testing Needed |
| <input type="radio"/> 3 Light Perception Only | <input type="radio"/> 9 Documented Functional Vision Loss |
| <input type="radio"/> 4 Totally Blind | |

Cortical Vision Impairment?

- 1 Yes 0 No 2 Unknown

Primary Classification of Hearing Impairment (Select the ONE that best describes the primary classification of the individual's hearing impairment):

- | | |
|---|--|
| <input type="radio"/> 1 Mild | <input type="radio"/> 5 Profound |
| <input type="radio"/> 2 Moderate | <input type="radio"/> 6 Diagnosed Progressive Loss |
| <input type="radio"/> 3 Moderately Severe | <input type="radio"/> 7 Further Testing Needed |
| <input type="radio"/> 4 Severe | <input type="radio"/> 9 Documented Functional Hearing Loss |

Central Auditory Processing Disorder (CAPD)?	<input type="radio"/> 1 Yes	<input type="radio"/> 0 No	<input type="radio"/> 2 Unknown
Auditory Neuropathy?	<input type="radio"/> 1 Yes	<input type="radio"/> 0 No	<input type="radio"/> 2 Unknown
Cochlear Implant?	<input type="radio"/> 1 Yes	<input type="radio"/> 0 No	<input type="radio"/> 2 Unknown

Etiology (please indicate the ONE etiology from the list below that best describes the primary etiology of the individual's primary disability. Please indicate "Other" if none of this listed etiologies are the primary disability):	
Hereditary/Chromosomal Syndromes and Disorders	
101 Aicardi syndrome 102 Alport syndrome 103 Alstrom syndrome 104 Apert syndrome (Acrocephalosyndactyly, Type 1) 105 Bardet-Biedl syndrome (Laurence Moon-Biedl) 106 Batten disease 107 CHARGE Syndrome 108 Chromosome 18, Ring 18 109 Cockayne syndrome 110 Cogan Syndrome 111 Cornelia de Lange 112 Cri du chat syndrome (Chromosome 5p-syndrome) 113 Crigler-Najjar syndrome 114 Crouzon syndrome (Craniofacial Dysostosis) 115 Dandy Walker syndrome 116 Down syndrome (Trisomy 21 syndrome) 117 Goldenhar syndrome 118 Hand-Schuller-Christian (Histiocytosis X) 119 Hallgren syndrome 120 Herpes-Zoster (or Hunt) 121 Hunter Syndrome (MPS II) 122 Hurler syndrome (MPS I-H) 123 Kearns-Sayre syndrome 124 Klippel-Feil sequence 125 Klippel-Trenaunay-Weber syndrome 126 Kniest Dysplasia 127 Leber congenital amaurosis 128 Leigh Disease 129 Marfan syndrome	130 Marshall syndrome 131 Maroteaux-Lamy syndrome (MPS VI) 132 Moebius syndrome 133 Monosomy 10p 134 Morquio syndrome (MPS IV-B) 135 NF1 - Neurofibromatosis (von Recklinghausen disease) 136 NF2 - Bilateral Acoustic Neurofibromatosis 137 Norrie disease 138 Optico-Cochleo-Dentate Degeneration 139 Pfeiffer syndrome 140 Prader-Willi 141 Pierre-Robin syndrome 142 Refsum syndrome 143 Scheie syndrome (MPS I-S) 144 Smith-Lemli-Opitz (SLO) syndrome 145 Stickler syndrome 146 Sturge-Weber syndrome 147 Treacher Collins syndrome 148 Trisomy 13 (Trisomy 13-15, Patau syndrome) 149 Trisomy 18 (Edwards syndrome) 150 Turner syndrome 151 Usher I syndrome 152 Usher II syndrome 153 Usher III syndrome 154 Vogt-Koyanagi-Harada syndrome 155 Waardenburg syndrome 156 Wildervanck syndrome 157 Wolf-Hirschhorn syndrome (Trisomy 4p) 199 Other _____
Pre-Natal/Congenital Complications 201 Congenital Rubella 202 Congenital Syphilis 203 Congenital Toxoplasmosis 204 Cytomegalovirus (CMV) 205 Fetal Alcohol syndrome 206 Hydrocephaly 207 Maternal Drug Use 208 Microcephaly 209 Neonatal Herpes Simplex (HSV) 299 Other _____	Post-Natal/Non-Congenital Complications 301 Asphyxia 302 Direct Trauma to the eye and/or ear 303 Encephalitis 304 Infections 305 Meningitis 306 Severe Head Injury 307 Stroke 308 Tumors 309 Chemically Induced 399 Other _____
Related to Prematurity 401 Complications of Prematurity	Undiagnosed 501 No Determination of Etiology

School Aged Settings (ages 6-21)

- | | |
|---|--|
| <input type="radio"/> 9 Attending the regular class at least 80% of the day | <input type="radio"/> 13 Attending a residential facility |
| <input type="radio"/> 10 Attending the regular class 40%-79% of the day | <input type="radio"/> 14 Homebound/Hospital |
| <input type="radio"/> 11 Attending the regular class less than 40% of the day | <input type="radio"/> 15 Correctional Facilities |
| <input type="radio"/> 12 Attending a separate school | <input type="radio"/> 8 Parentally place in private school |

Special Education Status/Part B Exiting

- | | |
|--|---|
| <input type="radio"/> 0 In ECSE or school-aged Special Education Program | <input type="radio"/> 5 Died |
| <input type="radio"/> 1 Transferred to regular education | <input type="radio"/> 6 Moved, known to be continuing |
| <input type="radio"/> 2 Graduated with regular diploma | <input type="radio"/> 7 (intentionally not used) |
| <input type="radio"/> 3 Received a certificate | <input type="radio"/> 8 Dropped out |
| <input type="radio"/> 4 Reached maximum age | |

Participation in Statewide Assessments

- | | |
|---|--|
| <input type="radio"/> 1 Regular grade-level state assessment | <input type="radio"/> 4 Alternative assessment/alternative standards |
| <input type="radio"/> 2 Regular grade-level state assessment w/ accommodations | <input type="radio"/> 5 Modified achievement standards |
| <input type="radio"/> 3 Alternative assessments aligned w/grade level standards | <input type="radio"/> 6 Not yet required |

Deaf-Blind Project Exiting Status

- | | |
|--|--|
| <input type="radio"/> 0 Eligible to receive services from the DB Project | <input type="radio"/> 1 No longer eligible to receive services from DB Project |
|--|--|

Assistive Technology

- | | | | |
|---------------------------------|-----------------------------|----------------------------|---------------------------------|
| Corrective Lenses | <input type="radio"/> 1 Yes | <input type="radio"/> 0 No | <input type="radio"/> 2 Unknown |
| Assistive Listening Devices | <input type="radio"/> 1 Yes | <input type="radio"/> 0 No | <input type="radio"/> 2 Unknown |
| Additional Assistive Technology | <input type="radio"/> 1 Yes | <input type="radio"/> 0 No | <input type="radio"/> 2 Unknown |

Intervener Services

- | | | | |
|-----------|-----------------------------|----------------------------|---------------------------------|
| Has a 1:1 | <input type="radio"/> 1 Yes | <input type="radio"/> 0 No | <input type="radio"/> 2 Unknown |
|-----------|-----------------------------|----------------------------|---------------------------------|

School Information

Agency/School:

Street Address:

City:

State:

ZIP Code:

Telephone Number

Fax Number:

Teacher's Name

Teacher's Email

School District

Please return this form by April 7, 2020.