COLORADO STATEWIDE CENSUS FOR CHILDREN AND YOUTH WITH COMBINED VISION AND HEARING LOSS (DEAFBLINDNESS)

Colorado Department of Education / Exceptional Student Services Unit
1560 Broadway, Suite 1175, Denver, Colorado 80202

Please complete the information on this form and return it to Tanni Anthony at the above address. Please refer to the Explanation of Certain Codes handout to assist you with completing this form. If you have any questions about the content of the Census Form, please call (303) 866-6681 or email Anthony_t@cde.state.co.us>.

Program Information

DATE: ____________________

Name of Contact Person: ____________________ Phone: ____________________

Contact Person's Email Address: ____________________

Contact Person's Address: ____________________

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Name of School District: ____________________
(Administrative Unit)

School/Agency Address Where Student Attends: ____________________

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Name of Student's Classroom Teacher____________________

Classroom Teacher Phone or Email address:____________________

Student's Personal Information

Last Name: ____________________ First & Middle Name: ____________________

SASID No. (found on IEP) ____________________ Date of Birth: ____________________

CO Code (CDE will populate):__________ Gender: (check one) Male = 00________Female = 01 ________

What is the primary language spoken in the student's home: ____________________

Race/Ethnicity: Circle **ONE** race / ethnicity code that *best* describes the student. **Any child that has any portion of Hispanic /Latino ethnicity must be classified solely as Hispanic/Latino.**

1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Hispanic / Latino
5. White
6. Native Hawaiian or Other Pacific Islander
7. Two or more races (no need to specify which races)

Parent/Guardian Information

Last Name: ____________________ First & Middle Name(s) ____________________

Address: ____________________City: ____________________

State:__Colorado________ Zip: ____________________County: ____________________

Telephone: ____________________ Email: ____________________

Primary Identified Etiology: Circle the **ONE** etiology code from the list below that best describes the primary diagnosis for the student's deafblindness. Specify *"other"* etiologies in the line beneath the chart.

Hereditary/Chromosomal Syndromes and Disorders	
101 Aicardi syndrome	130 Marshall syndrome
102 Alport syndrome	131 Maroteaux-Lamy syndrome (MPS VI)
103 Alstrom syndrome	132 Moebius syndrome
104 Apert syndrome (Acrocephalosyndactyly, Type 1)	133 Monosomy 10p
105 Bardet-Biedl syndrome (Laurence Moon-Biedl)	134 Morquio syndrome(MPS IV-B)
106 Batten disease	135 NF1-Neurofibromatosis(von Recklinghausen disease)
107 CHARGE association	136 NF2-Bilateral Acoustic Neurofibromatosis
108 Chromosome 18, Ring 18	137 Norrie disease
109 Cockayne syndrome	138 Optico-Cochleo-Dentate Degeneration
110 Cogan syndrome	139 Pfieffer syndrome
111 Cornelia de Lange	140 Prader-Willi
112 Cri du chat syndrome(Chromosome 5p-syndrome)	141 Pierre-Robin syndrome
113 Crigler-Najjar syndrome	142 Refsum syndrome
114 Crouzon syndrome(Craniofacial Dysotosis)	143 Scheie syndrome (MPS I-S)
115 Dandy Walker syndrome	144 Smith-Lemli-Opitz (SLO) syndrome
116 Down syndrome(Trisomy 21 syndrome)	145 Stickler syndrome
117 Goldenhar syndrome	146 Sturge-Weber syndrome
118 Hand-Schuller-Christian(Histiocytosis X)	147 Treacher Collins syndrome
119 Hallgren syndrome	148 Trisomy 13 (Trisomy 13-15, Patau syndrome)
120 Herpes-Zoster(or Hunt)	149 Trisomy 18 (Edwards syndrome)
121 Hunter syndrome (MPS II)	150 Turner syndrome
122 Hurler syndrome (MPS I-H)	151 Usher I syndrome
123 Kearns-Sayre syndrome	152 Usher II syndrome
124 Klippel-Feil sequence	153 Usher III syndrome
125 Klippel-Trenaunay-Weber syndrome	154 Vogt-Koyanagi-Harada syndrome
126 Kniest Dysplasia	155 Waardenburg syndrome
127 Leber congenital amaurosis	156 Wildervanck syndrome
128 Leigh Disease	157 Wolf-Hirchhorn syndrome(Trisomy 4p)
129 Marfan syndrome	199 Other__________________________

Pre-Natal/Congenital Complications	**Post-Natal/Non-Congenital Complications**
201 Congenital Rubella	301 Asphyxia
202 Congenital Syphilis	302 Direct Trauma to the eye and/or ear
203 Congenital Toxoplasmosis	303 Encephalitis
204 Cytomegalovirus (CMV)	304 Infections
205 Fetal Alcohol syndrome	305 Meningitis
206 Hydrocephaly	306 Severe Head Injury
207 Maternal Drug Use	307 Stroke
208 Microcephaly	308 Tumors
209 Neonatal Herpes Simplex (HSV)	309 Chemically Induced
299 Other__________________	399 Other________________________
Related to Prematurity	**Undiagnosed**
401 Complications of Prematurity	501 No Determination of Etiology

Other Cause of Deafblindness (please be as specific as possible): ____

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Information about the Student's Visual Impairment

Please provide information on the student's most current Functional Vision Assessment, which is a non-clinical assessment conducted by a certified teacher of students with visual impairments using commonly accepted assessment tools, checklists and measures for the purpose of making educated judgments about the functional use of vision.

Date of Functional Vision Assessment: ______________________ By Whom: _________________________

Does this student have a Learning Media Assessment Plan on file with his/her IEP? No = 0____ Yes = 1____

Primary Classification of Visual Impairment (Circle One that Best Describes the Student's Vision Impairment)
1. Low Vision (acuity of 20/70 to 20/200 **in the better eye with correction**.)
2. Legally Blind (acuity of 20/200 or less **or** field loss to 20 degrees or less **in the better eye with correction**.)
3. Light Perception Only
4. Totally Blind
6. Diagnosed Progressive Loss
7. Further Testing Needed to Determine Visual Impairment (can be selected for one year only)
Note: #s 5, 8, and 9 from the federal form have been deleted since they do not apply in Colorado

Does the child have a diagnosis of cortical/cerebral visual impairment? No = 0____ Yes = 1____ Unknown = 2____

Information about the Student's Hearing Impairment

Please provide information on the student's Functional Hearing Assessment, which is a non-clinical assessment conducted by a teacher certified in deafness using commonly accepted assessment tools, checklist and measures for the purpose of making educated judgment about the functional use of hearing.

Date of Functional Hearing Assessment: __________________ By Whom:________________________________

Does this student have a Communication Plan on file with his/her IEP? No = 0____ Yes = 1____

Primary Classification of Hearing Impairment (Circle One that Best Describes the Student's Hearing Loss)
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 to Determine Hearing Impairment (can be selected for one year only)
Note: #s 8 and 9 from the federal form have been deleted since they do not apply in Colorado

Does the student have a central auditory processing disorder**?** No = 0_____ Yes = 1_____ Unknown = 2_____
Does the student have auditory neuropathy? No = 0_____ Yes = 1_____ Unknown = 2_____
Does the student have a cochlear implant? No = 0_____ Yes = 1_____ Unknown = 2_____

Other Disabilities or Health Needs: Check the disabilities, in addition to the individual's combined visual and hearing impairments, which have a significant impact on the individual's developmental or educational progress.

Physical Disability No = 0_____ Yes = 1_____
Significant Limited Intellectual Capacity No = 0 _____ Yes = 1 _____
Significant Identifiable Emotional Disability No = 0 _____ Yes = 1 _____
Complex Health Care Needs No = 0 _____ Yes = 1 _____
Communication, Speech / Language Impairment No = 0_____ Yes = 1_____
Other Disabilities: No = 0 _____ Yes = 1 _____
Specify: ____

IDEA / Funding Category for Current Service

Part C Category Code: CHOOSE ONE: IF CHILD IS OLDER THAN THREE YEARS, CHOOSE 888
Student is receiving Part C Services: Yes = 2 _____ Not receiving Part C Services = 888 _______

Circle the ONE Part B Category Code from the list that identifies the primary disability label on the student's IEP.

Part B Category Code – this is the primary label on the student's IEP: CHOOSE ONLY ONE	
1. Significant Limited Intellectual Capacity 2. Hearing Disability 3. Speech-Language Impairment 4. Vision Disability 5. Significant Identifiable Emotional Disability 6. Physical Disability 8. Specific Learning Disability 9. Deafblindness	10. Multiple Disabilities 11. Autism 12. Traumatic Brain Injury 15. Preschooler with a Disability 888. Not Reported under Part B of IDEA *#s 7, 13, and 14 from the federal form have been deleted since they do not apply in Colorado*

Early Intervention or Educational Setting

Circle the **ONE** educational setting code from the appropriate age subcategories that best describes the student's education setting. Please find the section that describes the learner's age and fill out only that section.

Educational Setting	
Complete if Child is Ages Birth through Two Years	**Complete if Child is Ages Three to Five Years**
1. Home 2. Community-based settings 3. Other settings (please name setting below) ______________________	1. Attending a regular early childhood program at least 80% of the time 2. Attending a regular early childhood program 40-79% of the time 3. Attending a regular early childhood program less than 40% of the time 4. Attending a separate class 5. Attending a separate school 6. Attending a residential facility 7. Service provider location 8. Home
Complete if the Child is Ages Six to 21 Years	
9. Inside the general education class 80% or more of day 10. Inside the general education class 40% to 79% of the day 11. Inside the general education class less than 40% of the day 12. Separate school 13. Residential facility 14. Homebound / Hospital 15. Correctional facilities 16. Parentally placed in private schools 888. Not receiving Part B Services (i.e. home school)	

Participation in Statewide Assessments:

Circle the number representing the student's participation in the state's assessment activities.

1. Regular grade-level State Assessment (TCAP at 3rd-10th grades or the ACT at 11th grade)
2. Regular grade-level State Assessment (TCAP) with accommodations
3. Alternate assessment (CoALT at 3rd-10th grades or the 11th grade alternate portfolio)
6. Not required at age or grade level (infants, toddlers, preschoolers, K-2 grades, or 12th grade)

Note: # 4 and #5 from the federal form are not applicable with Colorado state assessments.

Part C Status or Exiting: This section is ONLY for children ages birth through two years. Please indicate the code that best describes the student's status on Dec. 1st. If the student is still in a Part C Early Intervention Program, circle 0. If they have exited from a Part C Early Intervention Program, please indicate the number that best describes the exit reason. Circle only one response for each Part C student.

COMPLETE THIS SECTION ONLY IF THE CHILD IS AGES BIRTH – TWO YEARS AS OF DEC 1

0. In a Part C Early Intervention Program (still receiving Part C services)
1. Completion of IFSP prior to reaching maximum age for Part C
2. Eligible for IDEA, Part B (transitioned into a school preschool program with an IEP)
3. Not eligible for Part B, exit with referrals to other programs
4. Not eligible for Part B, exit with no referrals
5. Part B eligibility not determined
6. Deceased
7. Moved out of state
8. Withdrawal by parent (or guardian)
9. Attempts to contact the parent and / or child were unsuccessful

Part B Status or Exiting: For students in early childhood/special education (preschool) or school-aged special education (3-21 years) indicate the code that best describes the student's status on Dec. 1st. If the student is still in a Part B special education program, circle 0. If they have exited from Part B special education services, please indicate the number that best describes the exit reason. Circle only one response for each Part B student.

COMPLETE THIS SECTION ONLY IF THE CHILD IS AGES THREE – 21 YEARS AS OF DEC 1

0. In Early Childhood Special Education or school-aged special education program
1. Transferred to general education (no longer has an IEP)
2. Graduated with a regular diploma
3. Received a certificate
4. Reached maximum age
5. Deceased
6. Moved, known to be continuing
8. Dropped out

Note: #7 is intentionally not used

Deafblind Project Exiting Status: Circle which number applies to the current status of the student. If the student is still considered to be a learner with deafblind needs, circle 0. If the student is no longer considered to be deafblind, please circle #1.

0. Eligible to receive services from the State Deafblind Project (student is deafblind)
1. No longer eligible to receive services from the State Deafblind Project (no longer deafblind)

Living Setting: Circle the living setting which the student resides the majority of the year. Circle only **ONE** choice.

Living Setting Information

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

555. Other (Specify)________________________

Information Specific to Equipment and Technology Specific to this Student

Wears Corrective Lenses	No = 0_____	Yes = 1_____	Unknown = 2_____
Uses Assistive Listening Devices	No = 0_____	Yes = 1_____	Unknown = 2_____
Uses Additional Assistive Technology	No = 0_____	Yes = 1_____	Unknown = 2_____

Please file a copy of this form in the student's file in your administrative unit / agency. The original should be mailed to:

Dr. Tanni Anthony
Colorado Department of Education
Exceptional Student Services Unit
1560 Broadway, Suite 1175
Denver, CO 80202

If there are any questions about this form, please contact Dr. Anthony at (303) 866-6681 or Anthony_t@cde.state.co.us This form must be signed by a district / agency contact person

______________________________________ ________________
Signature Date

____
Title