

**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: \_\_\_\_\_

Name of School District: \_\_\_\_\_  
(Administrative Unit)

School/Agency Address  
Where Student Attends: \_\_\_\_\_

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

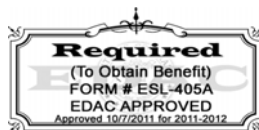
**Parent/Guardian Information**

Last Name: \_\_\_\_\_ First & Middle Name(s) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: Colorado Zip: \_\_\_\_\_ County: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_



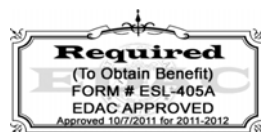
**Primary Identified Etiology:** Circle the **ONE** etiology code from the list below that **best describes** the primary diagnosis for the student’s deafblindness. Specify “*other*” etiologies in the line beneath the chart.

<b>Hereditary/Chromosomal Syndromes and Disorders</b>	
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 association 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 Dysotosis) 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_____
<b>Pre-Natal/Congenital Complications</b>	<b>Post-Natal/Non-Congenital Complications</b>
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_____	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_____
<b>Related to Prematurity</b>	<b>Undiagnosed</b>
401 Complications of Prematurity	501 No Determination of Etiology

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

\_\_\_\_\_

\_\_\_\_\_



## 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

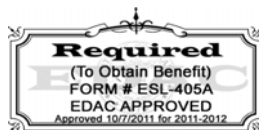
- 10. Multiple Disabilities
- 11. Autism
- 12. Traumatic Brain Injury
- 15. Preschooler with a Disability
- 888. Not Reported under Part B of IDEA

*#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.

<b>Educational Setting</b>	
<b>Complete if Child is Ages Birth through Two Years</b>	<b>Complete if Child is Ages Three to Five Years</b>
<ul style="list-style-type: none"> <li>1. Home</li> <li>2. Community-based settings</li> <li>3. Other settings (please name setting below)</li> </ul> <p style="text-align: center;">_____</p>	<ul style="list-style-type: none"> <li>1. Attending a regular early childhood program at least 80% of the time</li> <li>2. Attending a regular early childhood program 40-79% of the time</li> <li>3. Attending a regular early childhood program less than 40% of the time</li> <li>4. Attending a separate class</li> <li>5. Attending a separate school</li> <li>6. Attending a residential facility</li> <li>7. Service provider location</li> <li>8. Home</li> </ul>
<b>Complete if the Child is Ages Six to 21 Years</b>	
<ul style="list-style-type: none"> <li>9. Inside the general education class 80% or more of day</li> <li>10. Inside the general education class 40% to 79% of the day</li> <li>11. Inside the general education class less than 40% of the day</li> <li>12. Separate school</li> <li>13. Residential facility</li> <li>14. Homebound / Hospital</li> <li>15. Correctional facilities</li> <li>16. Parentally placed in private schools</li> <li>888. Not receiving Part B Services (i.e. home school)</li> </ul>	



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

<b>Wears Corrective Lenses</b>	No = 0 _____	Yes = 1 _____	Unknown = 2 _____
<b>Uses Assistive Listening Devices</b>	No = 0 _____	Yes = 1 _____	Unknown = 2 _____
<b>Uses Additional Assistive Technology</b>	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](mailto:Anthony_t@cde.state.co.us) This form must be signed by a district / agency contact person

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

