

DEAF-BLIND PROJECT CERTIFICATION CHECKLIST:

- ___ Cover page application
- ___ Current vision report by an ophthalmologist, optometrist or neurologist specializing in vision
- ___ Current audiologist report
- ___ Current IEP or IFSP
- ___ Functional Vision & hearing evaluations may be submitted for additional information (optional)
- ___ All sections on the Cover Page Application are completed and legible.



Email application to maltuna@kssdb.org
Or mail to Marites Altuna
Kansas Deaf-Blind Project
Kansas State School for the Blind, 1100 State Ave., Kansas City, KS 66102

Certification for Deaf-Blind Eligibility
Cover Page Application

This application is: Initial Certification _____ Recertification _____

Student Name: _____ Date of Birth: _____

Parent Name(s): _____

Email: _____ Phone Number: _____

Parent Street Address _____

City, Zip Code _____

USD# of attending district: _____ or Tiny-K Program _____

Attending School: _____

Address: _____ County _____

Contact Person: _____ Email: _____

Phone Number: _____

Address for Contact Person: _____

Vision Evaluation Summary

Date of Evaluation: _____ By Whom: _____

Findings: _____

Hearing Evaluation Summary

Date of Evaluation: _____ By Whom: _____

Findings: _____

Does the student have a cochlear implant? Circle one: YES NO

IEP or IFSP Summary

Date of Evaluation: _____ By Whom: _____

Findings: _____

CONSENT FROM PARENT(S) OR GUARDIAN(S):

- 1. I hereby authorize my consent for the Kansas Deaf-Blind Project to submit my child's name and Information to the Helen Keller National Center for additional services.

CIRCLE ONE: YES NO

Parent/Guardian Signature Date Relationship to Student

- 2. I hereby authorize my consent for the Kansas Deaf-Blind Project to submit my child's name and information to Families Together, Kansas State School for the Blind, Kansas School for the deaf.

CIRCLE ONE: YES NO

Parent/Guardian Signature Date Relationship to Student

- 3. **If your child has CHARGE Syndrome:** I hereby authorize my consent for the Kansas Deaf-Blind Project to submit my child's name and my contact information to the KS Parent Liaison of the CHARGE Syndrome Foundation.

CIRCLE ONE: YES NO

Parent/Guardian Signature Date Relationship to Student

DO NOT COMPLETE THIS SECTION:

___ Eligible for deaf-blind certification Initial certification Recertification 1 year Provisional
___ Ineligible for deaf-blind certification

Note:

Signed: _____ Date: _____ Recertification Date: _____