DEAF-BLIND PROJECT CERTIFICATION CHECKLIST:

____ Cover page application
____ Parent email(s)
____ 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 kkirchhoff@kssdb.org
Or mail to Katie Kirchhoff
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 give consent for my school/district to release information about my child to the Kansas Deaf-Blind Project. I also agree to allow consultants from the Kansas Deaf-Blind Project to observe my child in person or online and to provide technical assistance to the school team if requested by the school team.
   CIRCLE ONE: YES NO

2. I give 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

3. I give consent for the Kansas Deaf-Blind Project to submit my child's name and information to Kansas State School for the Blind, Kansas School for the deaf.
   CIRCLE ONE: YES NO

3. **If your child has CHARGE Syndrome:** I give 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:_____

Project Director