For Deaf-Blind Project Office Use ONLY: ID#: *Kidcode:*

2019 NM Deaf-Blind Census Reporting Form

UNM Project For New Mexico Children and Youth Who Are Deaf-Blind
2300 Menaul Blvd., NE
Albuquerque, New Mexico 87107
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505.272.0321 or Toll Free 877.614.4051
FAX: 505.272.3140

STOP!! Complete this form ONLY for individuals who have BOTH a visual and auditory 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*)

() 1. American Indian or Alaskan Native
() 2. Asian
() 3. Black or African American
() 4. Hispanic/Latino
() 5. White (Not Hispanic)
() 6. Native Hawaiian/Pacific Islander
() 7. Two or more races

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

() 1. Home: Birth/Adoptive 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 persons)
() 9. Pediatric Nursing Home
() 555: Other_____

Parent/Guardian Name 1 First:_____ Last:_____

Street Address: _____City:_____ State:_____ Zip:_____

Telephone: (____) _____ County of Residence:_____

Email address: (please print)_____

Parent/Guardian Name 2 First:_____ Last:_____

Street Address: _____City:_____ State:_____ Zip:_____

Telephone: (____) _____ County of Residence:_____

Email address: (please print)_____

Part II: Individuals Medical Background/Handicapping Conditions:

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

() 1. Low Vision
() 2. Legally Blind
() 3. Light Perception Only
() 4. Totally Blind
() 6. Diagnosed Progressive Loss
() 7. Further Testing Needed
() 9. Documented Functional Vision Loss

Cortical Vision Impairment? □ Yes □ No □ Unknown

Primary Classification of Hearing Impairment (*select the ONE that best describes the primary classification of the individual's auditory impairment):*

() 1. Mild
() 2. Moderate
() 3. Moderately Severe
() 4. Severe
() 5. Profound
() 6. Diagnosed Progressive Loss
() 7. Further Testing Needed (1 year only)
() 9. Documented Functional Hearing Loss

Central Auditory Processing Disorder (CAPD)?	() Yes	() No	() Unknown
Auditory Neuropathy?	() Yes	() No	() Unknown
Cochlear Implant?	() Yes	() No	() Unknown

Other Impairments? *(indicate Yes OR No for each):*

Orthopedic/Physical Impairments	()	Yes	()	No	Cognitive Impairments	()	Yes	() No
Behavioral Disorder	()	Yes	()	No	Complex Health Care Needs	()	Yes	() No
Communication Impairments	()	Yes	()	No	Other:_____	()	Yes	() No

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 the listed etiologies is the primary disability).***

1. Hereditary/Chromosomal Syndromes and Disorders

() 101. Aicardi Syndrome
() 102. Alport Syndrome
() 103. Alstrom Syndrome
() 104. Apert Syndrome (Acrocephalosyndactyly, Type!)
() 105. Bardet-Biedl Syndrome (Laurence Moon-Biedl)
() 106. Batten Disease
() 107. CHARGE Association
() 108. Chromosome Eighteen, Ring Eighteen
() 109. Cockayne Syndrome
() 110. Cogan Syndrome
() 111. Cornelial de Lange
() 112. Cri du chat Syndrome (Chromosome 5p-Syndrome)
() 113. Crigler-Naggar Syndrome
() 114. Crouzon Syndrome (Craniofacial Dysotosis)
() 115. Dandy Walker Syndrome
() 116. Down Syndrome (Trisomy Twenty-one)
() 117. Goldenhar Syndrome
() 118. Hand-Schuller-Christian (Histiocytosis X)
() 119. Hallgren Syndrome
() 120. Herpes-Zoster (or Hunt)
() 121. Hunter Syndrome (MPSII)
() 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 Anaurosis
() 128. Leigh Disease
() 129. Marfan Syndrome
() 130. Marshall Syndrome
() 131. Maroteaux-Lany Syndrome (MPS VI)
() 132. Moebius Syndrome
() 133. Monosomy Tenp
() 134. Morquio Syndrome (MPS IV-B)
() 135. NF One – Neurofibromatosis
() 136. NF Two – Bilateral Acoustic Neurofibromatosis
() 137. Norrie Disease
() 138. Optico-Cochleo Dentate Degeneration
() 139. Pfieffer Syndrome
() 140. Prader-Willi
() 141. Pierre-Robin Syndrome
() 142. Refsum Syndrome
() 143. Scheie Snydrome (MPS I-S)
() 144. Smith-Lemli – Optiz (SLO) Syndrome
() 145. Stickler Syndrome
() 146. Sturge-Weber Syndrome
() 147. Treacher Collins Syndrome
() 148. Trisomy Thirteen (Patau Syndrome)
() 149. Trisomy Eighteen (Edwards Syndrome)
() 150. Turner Syndrome
() 151. Usher I Syndrome
() 152. Usher II Syndrome
() 153. Usher III Syndrome
() 154. Vgot-Koyanagi-Harada Syndrome
() 155. Waarrdenburg Syndrome
() 156. Wildervanck Syndrome
() 157. Wolf-Hirschhorn Syndrome (Trisomy 4p)
() 199. Other _____

2. Pre-Natal/Congenital Complications

() 201. Congenital Rubella Syndrome
() 202. Congenital Syphilis
() 203. Congenital Toxoplasmosis
() 204. Cytomegalovirus (CMV)
() 205. Fetal Alcohol Syndrome
() 206. Hydrocephaly
() 207. Maternal Drug Use
() 208. Macrocephaly
() 209. Neonatal Herpes Simplex)
() 299. Other_____

3. 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

4. Related to Prematurity

() 401. Complications of Prematurity

5. Undiagnosed

() 501. No Determination of Etiology

Part III: IDEA

Part C - Birth through 2 Years

Special Education Status/Part C Exiting (*please indicate the ONE code that best describes the individual's Special Education Program status):*

() 0. In a Part C early intervention program
() 1. Completion of IFSP prior to reaching max age for Pt C
() 2. Eligible for IDEA Part B
() 3. Not eligible for Part B, referral to other program
() 4. Not eligible for Part B, exit with no referral
() 5. Part B eligibility not determined
() 6. Deceased
() 7. Moved out of state
() 8. Withdrawal by Parent/Guardian
() 9. Attempt(s) to reach parent/child unsuccessful.

Part C Category Code *(please indicate the primary category code under which the individual was reported on the Part C, IDEA Child Count. Select only ONE. See attached guideline for additional information if needed):*

() 1. At risk for developmental delays
() 2. Developmentally delayed
888 Not reported under Part C of IDEA

Part B – 3 through 21 Years

Special Education Status / Part B Exiting *(please indicate the ONE code that best describes the individual's Special Education Program status):*

() 0. In ECSE or school aged Special Education Program
() 1. Transferred to regular education
() 2. Graduated with regular diploma
() 3. Received a certificate
() 4. Reached maximum age
() 5. Died
() 6. Moved, known to be continuing
() 7. (intentionally not used)
() 8. Dropped out

Part B Category Code *(please indicate the primary category code under which the individual; was reported on Part B IDEA Child Count. Select ONE only. See attached Guideline for additional information, if needed):*

() 1. Intellectual Disability
() 2. Hearing Impairment (includes deafness)
() 3. Speech or Language Impairment
() 4. Visual Impairment (includes blindness)
() 5. Emotional Disturbance
() 6. Orthopedic Impairment
() 7. Other Health Impairment
() 8. Specific Learning Disability
() 9. Deaf-Blindness
() 10. Multiple disabilities
() 11. Autism
() 12. Traumatic Brain Injury
() 13. Developmentally Delayed – age 3 through 9
() 14. Non-Categorical
() 888. Not Reported under Part B of IDEA

Deaf-Blind Project Exiting Status:

Project staff to complete this section

() 0. Eligible to receive services from DB Project
() 1. No longer eligible to receive services from DB Project

Participation in Statewide Assessments

() 1. Regular grade level State assessment
() 2. Regular grade level State assessment w/accommodations
() 3. Alternate assessments
() 4. (intentionally not used)
() 5. (intentionally not used)
() 6. Not yet required at age or grade level
() 7. Parent Opt Out

Educational Setting *(indicate the ONE educational setting code from the appropriate age sub category that best describes the individual's educational setting. Please specify "OTHER" if none of the provided codes apply:*

Early Intervention Setting

Birth through 2 years of age (if the individual is in this category, please check the ONE box indicating the service(s) setting).

() 1. Home
() 2. Community based setting
() 3. Other setting(s)

Early Childhood Special Education (3-5) Setting

() 1. In a regular EC program at least 80% of the time
() 2. In a regular EC program 40% to 79% of the time
() 3. In a regular EC 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

School aged (6 – 21) Setting

() 9. Inside the regular class 80% or more of the day
() 10. Inside the regular class 40% to 79% of the day
() 11. Inside the regular classroom less than 40% of the day
() 12. Separate School
() 13. Residential facility
() 14. Homebound/Hospital
() 15. Correctional facility
() 16. Parentally placed in private school

Assistive Technology

Corrective Lenses	() Yes	() No	() Unknown
Assisted Listening Devices	() Yes	() No	() Unknown
Additional Assistive Technology	() Yes	() No	() Unknown

Intervener Services

An Intervener provides consistent one-to-one support to a student who is deaf-blind throughout the instructional day and has completed specialized training in deaf-blindness.

Is your child/student receiving Intervener Services?	() Yes	() No	() Unknown

School Information

Agency / School:_____

Street Address_____

City:_____ State:_____ Zip:_____

Telephone Number: (____)_____ Fax Number: (____)_____

Teacher/Coordinator Name: (*please print*) _____

Teacher/Coordinator Email Address: (*please print*) _____

School District: _____

Please return this form by April 8th, 2020

If you have any questions, please call

Project for New Mexico Children and Youth Who Are Deaf-Blind

505.272.0321 or Toll Free 877.614.4051

RETURN the Form by FAX: 505.272.3140 or mail:

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Thank you for completing this form, which will assist in program development, and funding!