# MO Deaf-Blind Census Reporting Form



| CHILD MOSIS#: | |
|---|---|
| STATE ID#: | |

## I. Information about the Individual (Child/Young Adult)

| 1. First Name: | | Last Name: | | Middle Initial: | |
|---|---|---|---|---|---|
| 2. Gender: | Male Female | 3. Child's Date of Birth: | month | day | year |
| 4. Child's County of Residence: | | | | | |
| 5. Parent/Guardian Name: | | | | | |
| Address: | | City/Town: | | Zip Code: | |
| Phone: | | Email: | | | |

*6.* Primary Identified Etiology *(Enter one numeric code in the box from the list below.)*

**HEREDITARY/CHROMOSAL SYNDROMES AND DISORDERS**

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 Syndrome
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. Pfieffer syndrome
140. Prader-Willi syndrome
141. Pierre-Robin syndrome
142. Refsum syndrome 3 Doc C-1
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 Syndrome, Type I
152. Usher Syndrome, Type II
153. Usher Syndrome, Type III
154. Vogt-Koyanagi-Harada syndrome
155. Waardenburg syndrome
156. Wildervanck syndrome
157. Wolf-Hirschhorn syndrome (Trisomy 4p)
199. Other:__________________________
**(Indicate the numeric code in the box above and specify in this space)**

**PRE-NATAL/CONGENITAL COMPLICATIONS**

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:____________________________
**(Indicate the numeric code in the box above and specify in this space)**

**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:____________________________
(Indicate the numeric code in the box above and specify in this space)

**RELATED TO PREMATURITY**

401. Complications to Prematurity

**UNDIAGNOSED**

501. No determination of Etiology

| **7. Ethnicity** | 1.American Indian or Alaskan Native | 2.Asian | 3.Black/African American | 4.Hispanic | 5.White | 6. Native Hawaiian/ Pacific Islander | 7. Two or more races |
|---|---|---|---|---|---|---|---|

**8. Primary language spoken in the home:**

| 1.English | 4. German | 7. French |
|---|---|---|
| 2. Spanish | 5. Serbo-Croatian | 8. Vietnamese |
| 3. Chinese | 6. Arabic | 9. Other: |

## II. Information about Vision, Hearing, and Other Impairments

*1.** **Documented Vision Loss** *Select **ONE** that best describes the individual's:*

A. Documented degree of vision loss with correction, or
B. Indicate that further testing is needed (testing must be complete prior to the next census submission) or
C. Indicate that the student has a documented functional vision loss.

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

# MoDBTAP Census Form

**2.* Documented Hearing Loss** *Select **ONE** that best describes the individual's:*

A. Documented degree of hearing loss with correction, or
B. Indicate that further testing is needed (testing must be complete prior to the next census submission) or
C. Indicate that the student has a documented functional hearing loss.

| | | |
|---|---|---|
| 1.Mild (26-40 dB loss) | 4.Severe (71-90 dB loss) | 7.Further Testing Needed |
| 2.Moderate (41-55 dB loss) | 5.Profound (91+ dB loss) | 9.Documented Functional Hearing Loss |
| 3.Moderately Severe (56-70 dB loss) | 6.Diagnosed Progressive Loss | |

| 3. Does the child have any of the following: | 4. Indicate all other documented impairments, in addition to vision and hearing loss: |
|---|---|
| Auditory Neuropathy | Physical Impairments |
| Central Auditory Processing Disorder (CAPD) | Cognitive Impairments |
| Cochlear Implant | Behavior Disorder |
| Cortical Visual Impairment | Complex Health Care Needs |
| Other: | Communication/Speech and Language |
| Other: | Other: |

## III. Reporting, Funding and Placement Information

**1. Part C Reporting Category.** ***If the child is 0-2 years of age please enter the category under which the child was reported within the Early Intervention program (Department of Health). [Select one]***

| | | |
|---|---|---|
| At-risk for developmental delay | Developmentally Delayed | Not reported under Part C |

**2. Part B Reporting Category Code.** ***If the child is 3-21 years of age indicate the primary category code under which the individual was reported on Part B, IDEA Child Count. [Select one]***

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

**3. Early Intervention Setting (0-2).** ***Please specify where the child receives services.***

| | | |
|---|---|---|
| 1.Home | 2.Community-Based Setting | 3. Other [please specify]: |

**4. Educational setting 3-5 years of age.** ***Please choose the one which best describes which type of program the child attends.***

| | |
|---|---|
| 1.Attending a regular early childhood program at least 80% of the time. | 5.Attending a separate school. |
| 2.Attending a regular early childhood program 40% to 79% of the time. | 6.Attending a residential facility. |
| 3.Attending a regular early childhood program less than 40% of the time. | 7.Service provider location. |
| 4.Attending a separate class. | 8.Home |

**5. Educational setting 6-21 years of age.** ***Please choose the one which best describes the type of program the child attends.***

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

**6.Participation in Statewide Assessments:** ***Please indicate what assessment system the child participates in.***

1.Regular grade-level State assessment.
2.Regular grade-level State assessment with accommodations.
3.Alternative Assessment aligned with grade level.
6.Not required at age or grade level.

**7. Special Education Status/Part C (0-2) 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 maximum age for Part C.
2.Eligible for IDEA, Part B.
3.Not eligible for Part B, referral to other program.
4.Not eligible for Part B, exit without referrals.
5.Part B eligibility not determined.
6.Deceased.
7.Moved out of state.
8.Withdrawal by parent/guardian.
9.Could not contact parent.

**8. Special Education Status/Part B Exiting.** ***Please indicate the ONE code that best describes the individual's special education program status on December first of the current year.***

0.In early childhood or school-age special education.
1.Transferred to regular education.
2.Graduated with regular high school diploma.
3.Received a certificate.
4.Reached maximum age.
5.Deceased.
6.Moved, Known to be Continuing.
8.Dropped Out.

**9. Current living setting:**

1.Home: Parents
2.Home: Extended Family
3.Home: Foster Parents
4.State Residential Facility
5. Private Residential Facility
6. Group home (fewer than 6 residents)
7. Group home (6 or more residents)
8. Apartment (with non family)
9. Pediatric nursing home
555. Other

**10. Does this individual use any of the following adaptive equipment?**

Corrective Lenses
Assistive Listening Devices (i.e. hearing aids or FM system)
Additional Assistive Technology (other than corrective lenses or assistive listening devices)

**11. School Information**

| | | | | | |
|---|---|---|---|---|---|
| Agency/School Name: | | | | | |
| Street Address: | | | | | |
| City: | | State: | | Zip Code: | |
| Telephone Number: | | Fax Number: | | | |
| Teacher Name: | | Teacher's Email: | | | |

**12. Is this individual receiving services from an Intervener/one-on-one paraprofessional?**

Yes No

**13. Name of individual completing reporting form**

| | | | |
|---|---|---|---|
| Name: | | Title/Relationship: | |
| Email: | | Phone: | |
| Signature: | | Date: | |

Please return this form **and** the appropriate Release Form to:

Megan Burgess, Deaf-Blind Project Coordinator
Megan.Burgess@msb.dese.mo.gov
Fax: (314)773-3762
3815 Magnolia Ave, St. Louis MO 63110

If you have any questions or need assistance in completing this form please contact us at:(314)633-1587 or email Megan.Burgess@msb.dese.mo.gov