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Florida & Virgin Islands Deaf-Blind Collaborative

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Under HIPAA, Florida providers (https://www.cms.gov/HIPAAGenInfo/Downloads/CoveredEntitycharts.pdf) may disclose de-identified information to the registry of children who are deaf-blind without authorization. In compliance with HIPAA, the Deaf-Blind Collaborative transmits only de-identified information about health and disability demographics to the National Center on Deaf-Blindness for the annual census (http://privacyruleandresearch.nih.gov/pr_08.asp).

PLEASE COMPLETE THE CENSUS FORMS AND RETURN BY FAX (352-273-8539) OR MAIL

To The Florida & Virgin Islands Deaf-Blind Collaborative. Thank you.

PLEASE DO NOT RETURN CENSUS INFORMATION BY EMAIL, AS EMAIL IS NOT A HIPAA-COMPLIANT METHOD

QUESTIONS? CALL SHELLY AT 352-273-7534 OR 800-667-4052

Help the Deaf-Blind Collaborative to help children with deaf-blindness and their families!

Encourage families to complete a **Consent for the Exchange of Information & Records**, so that we can provide information and offer services to children with deaf-blindness, their families, and their educational teams.

Once a family has provided consent, any family member or team member may make a **Request for Technical Assistance** from the Florida & Virgin Islands Deaf-Blind Collaborative.

For Deaf-Blind Project Office use only: Kidcode/ID# _____

Deaf-Blind Census Reporting Form for HIPAA-covered Entities

Please use this form to report any student (ages 0-21) with vision AND hearing losses (documented or suspected). USE THIS FORM to report AS MUCH INFORMATION AS POSSIBLE on students (ages 0 through 21) with BOTH vision loss AND hearing loss.

Please return forms by fax to: 352-273-8539

Questions? Call Shelly at 352-273-7534 or toll free at 800-667-4052

Name/Title of Person Completing this Form: _____

Best contact Phone: _____ Email: _____

Part I: Information about the child/youth with deaf-blindness

Year of Birth _____ **Gender** (please circle) Male / Female

Race / Ethnicity (select the term that best describes the student's race/ethnicity): ___ Multi-racial

___ American Indian or Alaskan native ___ Asian ___ Hispanic ___ White (not Hispanic) ___ Black (not Hispanic)

Living Setting (Select the ONE setting that best describes where the student resides most of the year.):

___ 1 Home: Birth/Adoptive Parents ___ 2 Home: Extended Family ___ 2 Home: Extended Family

___ Other: _____

Part II: Student's Levels/Types of Sensory Loss

Primary Classification of Vision Loss (please select the level that best describes vision loss in each eye)

Right eye: ___ Low vision ___ Legal Blindness ___ Light Perception ___ Totally Blind ___ Suspected

Left eye: ___ Low vision ___ Legal Blindness ___ Light Perception ___ Totally Blind ___ Suspected

Primary Classification of Hearing Loss (circle the level that best describes hearing loss in each ear)

Right ear: ___ Mild ___ Moderate ___ Moderately Severe ___ Severe ___ Profound ___ Suspected

L**eft ear:** ___ Mild ___ Moderate ___ Moderately Severe ___ Severe ___ Profound ___ Suspected

Please answer the following questions with "yes" or "no," or "unknown"

Cochlear Implant? Yes / No **Physical Disabilities?** Yes / No **Cognitive Disabilities?** Yes / No

Complex Health Care Needs? Yes / No **Behavioral Disorder?** Yes / No

Etiology (please select ONE etiology from one category) Hereditary/Chromosomal Syndromes

Please name and/or describe the inherited or genetic condition (e.g., Cri du chat syndrome):

_____

_____

_____

_____

Etiology (please select ONE etiology from ONE category) Pre-Natal/Congenital Complications

___ Congenital Rubella Syndrome ___ Congenital Syphilis ___ Toxoplasmosis ___ Cytomegalovirus (CMV)

___ Fetal Alcohol Syndrome ___ Hydrocephaly ___ Maternal Drug Use ___ Microcephaly

___ Neonatal Herpes Simplex

299 Other (describe/explain): _____

Etiology (please select ONE etiology from ONE category) Post-Natal/Non-Congenital Complications

___ Asphyxia ___ Direct Trauma to the eye and/or ear ___ Encephalitis ___ Infections

___ Meningitis ___ Severe Head Injury ___ Stroke ___ Tumors: _____

___ Other (please describe/explain): _____

___ Complications of Prematurity ___ No determination of etiology (unknown/undiagnosed)

Please select the IDEA funding category under which the student received services on December 1, 2013:

_____ IDEA Part B (three through 21 years) _____ IDEA Part C (birth through two years)

Educational Setting (please select the student's CURRENT educational setting):

Early Intervention Setting (birth through age 2)

___ Home ___ Other: _____

OR Early Childhood (EC) Special Education Setting (ages 3-5)

___ Regular EC program at least 80% of the time ___ Regular EC program at least 40-79% of the time

___ Regular EC program less than 40% of the time

___ Separate class ___ Separate school

___ Other: _____

___ Home, please circle one: homebound / homeschooled