



Greater Minnesota Psychological Assessments for Deaf, Hard of Hearing and Deafblind Students 2026-2027: Application Form

PLEASE NOTE: This is considered an “outside evaluation” and will require parent/guardian consent. Please confirm that the parent/guardian is interested in an evaluation by a psychologist outside the student’s school (a psychologist that is fluent in ASL with training/experience working with individuals with hearing loss) before submitting an application. Thank you!

Application date: _____ **Referred by:** _____

Relationship to student: ☐ Parent ☐ Teacher ☐ Other (specify): _____

Phone: _____ **Email:** _____

Student Information

Choose one level of service: ☐ Intellectual/Adaptive Only Evaluation OR ☐ Full Evaluation

Student Name: _____ **DOB:** _____ **Age:** _____

Gender: ☐ Male ☐ Female

Ethnicity:

- ☐ American Indian
- ☐ Asian American
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ White/Caucasian
- ☐ Other: _____

County Assistance:

- ☐ Minnesota Family Investment Program
- ☐ County social worker
- ☐ Other county assistance: _____
- ☐ No county assistance

Student Address: _____ **City:** _____ **State:** _____ **Zip:** _____



Parent/Guardian Information

Parent/Guardian #1: _____ **Email:** _____ **Phone:** _____

Address (if different from student's): _____ **City:** _____ **State:** _____ **Zip:** _____

Parent/Guardian #2: _____ **Email:** _____ **Phone:** _____

Address (if different from student's): _____ **City:** _____ **State:** _____ **Zip:** _____

Evaluation Information

School district: _____ **School name:** _____

3-year special education evaluation due date (month/day/year): _____

Reason(s) the evaluation is needed (Intellectual/Cognitive/IQ Testing):

(Check all that apply)

☐ Attention

☐ Memory

☐ Learning

☐ Adaptive/Self-Help/Independence Skills

☐ Social Functioning

☐ Emotional Functioning (anxiety, mood, emotional control)

☐ Behavioral Functioning

☐ Autism Evaluation

☐ Developmental Skills

Comment (optional):



Medical Conditions/Other Special Education Categories/Mental Health Conditions:

(Check all that apply)

- | | |
|--|--|
| ☐ None | ☐ Attention Deficit and Hyperactivity Disorder |
| ☐ Developmental Cognitive Delay | ☐ Mood Disorder (i.e. Depression, Bipolar Disorder) |
| ☐ Developmental Delay | ☐ Anxiety Disorder (General Anxiety Disorder, Social Anxiety) |
| ☐ DeafBlind | ☐ Seizure Disorder |
| ☐ Autism Spectrum Disorder | ☐ Other (specify): _____ |
| ☐ Speech or Language Impairments | |
| ☐ Specific Learning Disabilities | |
| ☐ Emotional or Behavioral Disorders | |

Degree of Hearing Loss (Choose one):

- | | | | |
|-------------------------------|-----------------------------------|---------------------------------|-----------------------------------|
| ☐ Mild | ☐ Moderate | ☐ Severe | ☐ Profound |
|-------------------------------|-----------------------------------|---------------------------------|-----------------------------------|

Type of Hearing Loss (Choose one):

- | | | |
|--|-------------------------------------|--------------------------------|
| ☐ Sensorineural | ☐ Conductive | ☐ Mixed |
|--|-------------------------------------|--------------------------------|

Unilateral or Bilateral? (Choose one):

- | | | |
|------------------------------------|--|---|
| ☐ Bilateral | ☐ Unilateral Left Ear | ☐ Unilateral Right Ear |
|------------------------------------|--|---|

Has the student been diagnosed with Auditory Neuropathy Disorder? (Choose one):

- | | |
|------------------------------|-----------------------------|
| ☐ Yes | ☐ No |
|------------------------------|-----------------------------|

Does the student have vision loss?

- | | |
|------------------------------|-----------------------------|
| ☐ Yes | ☐ No |
|------------------------------|-----------------------------|

If the student has vision loss, explain:



Amplification (Check all that apply):

- | | |
|--|---|
| ☐ Bilateral Cochlear Implants | ☐ Unilateral Hearing Aid – Right Ear |
| ☐ Unilateral Cochlear Implant-Right Ear | ☐ Unilateral Hearing Aid – Left Ear |
| ☐ Bilateral Hearing Aids | ☐ FM system |
| ☐ Unilateral Cochlear Implant –Left Ear | ☐ Other (specify): _____ |
| | ☐ None |

Comment (optional):

Communication Methods the Student Uses AT HOME (Check all that apply):

- | | |
|---|---|
| ☐ Spoken English | ☐ Cued Language |
| ☐ Other spoken language (specify): _____ | ☐ Total Communication |
| ☐ American Sign Language | ☐ Picture Communication System |
| ☐ Tactile American Sign Language | ☐ Other (specify): _____ |
| | ☐ None |

Comment (optional):

Communication Methods the Student Uses AT SCHOOL (Check all that apply)

- | | |
|---|---|
| ☐ Spoken English | ☐ Tactile American Sign Language |
| ☐ Other spoken language (specify): _____ | ☐ Total Communication |
| ☐ American Sign Language | ☐ Picture Communication System |
| ☐ Cued Language | ☐ Other (specify): _____ |

Comment on school communication methods (optional):



Support Staff/Interpreters (*Check all that apply*):

- | | |
|---|---|
| ☐ Part time special education paraprofessional | ☐ Full Time ASL Interpreter |
| ☐ Full time special education paraprofessional | ☐ Cued Language Transliterator |
| ☐ DeafBlind Intervener | ☐ Other (specify): _____ |
| ☐ Part Time ASL Interpreter | |

Comment (optional):

Student's Educational Placement (*Check all that apply*):

- | | |
|---|---|
| ☐ In Home Services | ☐ Pull out Special Education Services |
| ☐ Special Education Resource Room-more than 50% of the day | ☐ Push In Special Education Services |
| ☐ Special Education Resource Room-less than 50% of the day | ☐ Residential School for the Deaf or Blind |
| ☐ Mainstream | ☐ Other (specify): _____ |

Comment (optional):
