

COLORADO STATEWIDE CENSUS FOR CHILDREN AND YOUTH WITH COMBINED VISION AND HEARING LOSS (DEAF-BLINDNESS)

Colorado Department of Education / Exceptional Student Services Unit
201 East Colfax Avenue, Room 409, Denver, Colorado 80203
Part C Form (only use this form for infants and toddlers / ages birth through 2 years)

Please complete the information on this form and return it through the CDE Secure Portal. Please refer to the Explanation of Certain Codes handout to assist you with completing this form. If you have any questions about the content of the Census Form, please call (303) 503-4647 or email Anthony_T@cde.state.co.us.

CHILD NAME: _____ **ID Code (CDE will populate):** _____

Name of Person filling out this form: _____

AGENCY INFORMATION (1): (if child is older than 3 years, you should be using the Part B Form and not this Form)

Name of Agency: _____

Contact Person: _____ Phone: _____

Agency Address: _____

City: _____ State: CO Zip Code: _____

Contact Person's Email Address: _____

AGENCY INFORMATION (2):

Name of Agency: _____

Contact Person: _____ Phone: _____

Agency Address: _____

City: _____ State: CO Zip Code: _____

Contact Person's Email Address: _____

AGENCY INFORMATION (3):

Name of Agency: _____

Contact Person: _____ Phone: _____

Agency Address: _____

City: _____ State: CO Zip Code: _____

Contact Person's Email Address: _____

***If additional agencies need to be added, please use the additional agency form at the end.**

Child's Personal Information

Last Name: _____ First & Middle Name: _____

Date of Birth: _____ Gender: (check one) ☐ Male = 00 ☐ Female = 01 ☐Other = 02

Date Deaf-Blind eligibility determined: (MM/DD/YYY): _____

Required
(To Obtain Benefit)
FORM # ESL-405A
EDAC REVIEWED
11/07/2025 for 2025-2026

Ethnicity (check one) ☐ No child is not Hispanic/Latino ☐ Yes child is Hispanic/Latino

Race: Check **ONE** race code that best describes the student**.**

☐ 1. American Indian or Alaska Native
☐ 2. Asian
☐ 3. Black or African American
☐ 5. White
☐ 6. Native Hawaiian or Other Pacific Islander
☐ 7. Two or more races (no need to specify which races)

Note*: 4 from the form has been deleted to align with federal reporting guidelines*

Primary language in the home (check one) ☐ English = 01 ☐ Spanish = 02 ☐ ASL = 03
☐ Other = 9 _____

Parent/Guardian Information (Please assure you have the most recent / accurate address information).
Please complete two contact information fields, if parents or legal guardians have two different last names.

Parent Last Name: _____ First Name: _____

Parent Last Name: _____ First Name: _____

Address: _____

City: _____ State: Colorado Zip: _____ County: _____

Telephone: _____ Email: _____

Living Setting: Circle the living setting in which the student resides the majority of the year.
Check only **ONE** choice.

Living Setting Information

☐ 01. Home: With Parents
☐ 02. Home: Extended Family
☐ 03. Home: Foster Parents
☐ 04. State Residential Facility
☐ 05. Private Residential Facility
☐ 09. Pediatric Nursing Home
☐ 10. Community Residence (Includes group home /supported apartment)
☐ 555. Other (Specify): _____

IDEA Category for Current Service: Check One Choice

☐ IDEA Part C = 01 ☐ Not receiving IDEA Part C services = 03 ☐ Unknown, Missing = 999

Part C Category Code: Check One Choice

☐ Under the age of three - At Risk = 01 ☐ Developmental Delayed = 02

☐ Not reported under IDEA Part C = 888 ☐ Unknown, Missing = 999

Early Intervention Setting (Birth through 2) Information About Field Choices

Home: Early intervention services are provided primarily in the principal residence of the child's family or caregivers.

Community-based settings: Early intervention services are provided primarily in a setting where children without disabilities typically are found. These settings include but are not limited to childcare centers (including family day care), preschools, regular nursery schools, early childhood center, libraries, grocery stores, parks, restaurants, and community centers (e.g., YMCA, Boys and Girls Clubs).

Other settings: Early intervention services are provided primarily in a setting that is not home, or community based. These settings include, but are not limited to, services provided in a hospital, residential facility, clinic, and EI center/class for children with disabilities.

Early Intervention Setting: Check the ONE educational setting code from the appropriate age subcategories that best describe the student's early intervention setting. Please find the section that describes the child's age and fill out only that section.

Early Intervention Setting - Complete if Child is Under the Age of Three Years

☐ 01. Home ☐ 02. Community ☐ 03. Other Settings ☐ 888. Part C age but not served under Part C

Complete if Child will turn Three (3) within the next year

1. Date student will transition to Part B: (DD/MM/YYYY) _____

2. What School District: _____

Part C Status or Exiting: For children in early intervention (under the age of three years) indicate the code that best describes the learner's status on December 1st of this year. If the child is still in a Part C special education program, check (0.) If they have exited from Part C special education services, please indicate the number that best describes the exit reason. Check only one response.

☐ 00. Not exited, In Part C early intervention program
☐ 01. Completion of IFSP prior to reaching maximum age for Part C
☐ 02. Eligible for IDEA Part B Services
☐ 03. Not Eligible for Part B, exit to another program
☐ 04. Not eligible, exit with no referrals
☐ 05. Part B eligibility not determined
☐ 06. Deceased
☐ 07. Moved Out of State
☐ 08. Withdrawal by a parent (or guardian)
☐ 09. Attempts to contact the parent were unsuccessful
☐ 888. Child not served under Part C (the child is three years or older)

Primary Identified Etiology: Circle the **ONE** etiology code from the list below that best describes the primary diagnosis for the student's deaf-blindness. Specify "other" etiologies in the line beneath the chart.

Hereditary/Chromosomal Syndromes and Disorder

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 association
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
141 Pierre-Robin syndrome
142 Refsum syndrome
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 I syndrome
152 Usher II syndrome
153 Usher III syndrome
154 Vogt-Koyanagi-Harada syndrome
155 Waardenburg syndrome
156 Wildervanck syndrome
157 Wolf-Hirchhorn syndrome (Trisomy 4p)
199 Other_____

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_____

Related to Prematurity

401 Complications of Prematurity

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
308 Tumors
309 Chemically Induced
399 Other_____

Undiagnosed

501 No Determination of Etiology

Other Cause of Deaf-blindness (please be as specific as possible): _____

_____

_____

Information about the Child's Blindness/Low Vision: Please provide information on the child's most current Functional Vision Assessment, which is a non-clinical assessment conducted by a Teacher of Students with Visual Impairments.

Date of Functional Vision Assessment: _____ By Whom: _____

Primary Classification of Blindness/Low Vision
(Circle One that Best Describes the Student's Blindness / Low Vision)

1. Low Vision (acuity of 20/70 to 20/200 **in the better eye with correction**.)
2. Legally Blind (acuity of 20/200 or less **or** field loss to 20 degrees or less **in the better eye with correction**.)
3. Light Perception Only
4. Totally Blind
6. Diagnosed Progressive Loss
7. Further Testing Needed to Determine Visual Impairment (can be selected for one year only)

***Note**: s 5, 8, and 9 from the federal form have been deleted since they do not apply in Colorado*

Does the child have a diagnosis of cortical/cerebral visual impairment? ☐ No = 0 ☐ Yes = 1 ☐ Unknown = 2
Does the child wear corrective lenses (glasses, contacts) (check one): ☐ No = 0 ☐ Yes = 1 ☐ Unknown = 2

Information about the Student's Deafness / Hearing Difference: Please provide information on the child's Functional Hearing Assessment, which is a non-clinical assessment conducted by a Teacher of the Deaf.

Date of Functional Hearing Assessment: _____ By Whom: _____

Primary Classification of Deafness / Hearing Difference Circle One that Best Describes the Student's Deafness/Hering Difference)

1. Mild (26-40 dB loss)
2. Moderate (41-55 dB loss)
3. Moderately Severe (56-70 dB loss)
4. Severe (71-90 dB loss)
5. Profound (91+ dB loss)
6. Diagnosed Progressive Loss
7. Further Testing Needed to Determine Deafness/Hearing Difference (can be selected for one year only)

***Note:** #s 8 and 9 from the federal form have been deleted since they do not apply in Colorado*

Does the student have a central auditory processing disorder? ☐ No = 0 ☐ Yes = 1 ☐ Unknown = 2
Does the student have auditory neuropathy? ☐ No = 0 ☐ Yes = 1 ☐ Unknown = 2
Does the student have a cochlear implant? ☐ No = 0 ☐ Yes = 1 ☐ Unknown = 2

If yes, date of implant: Right: _____ Left: _____

Does the student use Assistive Listening Devices ☐No = 0 ☐ Yes = 1 ☐ Unknown = 2

Other Concern Areas or Health Needs: Check the concern areas, in addition to the child's combined visual and hearing impairments that have a significant impact on the individual's developmental or educational progress. Please consider each area carefully and work to not select the choice of unknown as expect the early intervention team to know this information.

Orthopedic Disability (e.g., cerebral palsy)	☐ No = 0	☐ Yes = 1	☐ Unknown = 2
Intellectual Disability	☐ No = 0	☐ Yes = 1	☐ Unknown = 2
Serious Emotional Disability (mental health/behavior)	☐ No = 0	☐ Yes = 1	☐ Unknown = 2
Other Health Impairment (e.g., seizure disorder)	☐ No = 0	☐ Yes = 1	☐ Unknown = 2
Speech / Language Impairment	☐ No = 0	☐ Yes = 1	☐ Unknown = 2
Other educational concerns:	☐ No = 0	☐ Yes = 1	

Specify Other Concerns: _____

Information Specific to Equipment and Technology / Intervener Status Specific to this Child

Does the child use additional Assistive Technology	☐ No = 0	☐ Yes = 1	☐ Unknown = 2
Does the child receive services from an Intervener	☐ No = 0	☐ Yes = 1	☐ Not Applicable = 888

If this child has Intervener, is the intervener: ☐ Credentialed ☐ Certified ☐ Not credentialed or certified

Deaf-Blind Project Status: Check which number applies to the current status of the student. If the student is still considered to be a learner with deafblind needs, check 0. If the student is no longer considered to be deaf-blind, please check #1.

☐ 0. Eligible to receive services from the State Deafblind Project (student is deaf-blind)
☐ 1. No longer eligible to receive services from the State Deaf-Blind Project (no longer deaf-blind)

Notes: _____

_____

_____

Please file a copy of this form in the student's file in your administrative unit / agency. The original should be sent through the CDE Secure File Transfer Server.

If there are any questions about this form, please contact Dr. Anthony at (303) 503-4647 or Anthony_t@cde.state.co.us. This form must be signed by a district / agency contact person.

Signature: _____ Date: _____

Title: _____