



# Is Your Child Eligible for Deafblind Status?

(Use this form for suspected or confirmed deaf blindness)

## Child's Information

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Date of Birth

Gender  Male  Female

\_\_\_\_\_  
School District in which Child **RESIDES**

\_\_\_\_\_  
County in which Child **RESIDES**

\_\_\_\_\_  
School/Program Child **CURRENTLY ATTENDS**, if any

**Child's Hearing Loss** - Check only one

Confirmed  Suspected

**Child's Vision Loss** - Check only one

Confirmed  Suspected

### Child's Residence

(Check in front of the choice that best describes the child's primary place of residence.)

- Child lives exclusively with Parent 1
  - Child lives exclusively with Parent 2
  - Child lives with Parent 1 and Parent 2
  - Child lives half the time with each parent
  - Other - Please describe below
- \_\_\_\_\_

## Parent #1 Information

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email Address



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## Parent #2 Information

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Email Address

## Professional Contact Person Information - School District or Birth to 3 Program

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
School or Agency

\_\_\_\_\_  
FAX Number

\_\_\_\_\_  
School or Agency Street Address

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
CESA Closest to School or Agency

## Person Completing This Application

\_\_\_\_\_  
Name of Person Completing this Application

\_\_\_\_\_  
Signature of Person Completing this Application

\_\_\_\_\_  
Date Application Completed

Please fax completed form to WDBTAP at (608) 355-2042 or mail to:  
WDBTAP Office Associate, 124 2nd St., Suite 35, Baraboo, WI 53913

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