GREATER MINNESOTA PSYCHOLOGICAL ASSESSMENTS FOR DEAF, HARD OF HEARING & DEAFBLIND STUDENTS

2017-18 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

Name _____

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 _____

Gender: ☐Male ☐Female DOB _____ Age _____

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

Address (street, city, state, zip) _____

Parent/Guardian #1 _____

Email _____ Phone _____

Address (if different from student's) _____

Parent/Guardian #2 _____

Email _____ Phone _____

Address (if different from student's) _____

School district _____ School name _____

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

Reason(s) the evaluation is needed *(Check all that apply)*

☐Intellectual/Cognitive/IQ Testing
☐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
☐Developmental Cognitive Delay
☐Developmental Delay
☐DeafBlind
☐Autism Spectrum Disorder
☐Speech or Language Impairments
☐Specific Learning Disabilities
☐Emotional or Behavioral Disorders
☐Attention Deficit and Hyperactivity Disorder
☐Mood Disorder (i.e. Depression, Bipolar Disorder)
☐Anxiety Disorder (General Anxiety Disorder, Social Anxiety)
☐Seizure Disorder
☐Other (specify) _____

Degree of Hearing Loss *(Choose one)*

☐Mild ☐Moderate ☐Severe

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 here

Amplification *(Check all that apply)*

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

Comment (optional)

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

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

☒Other (specify) _____

Comment (optional)

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

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

☐Other (specify) _____

Comment on school communication methods (optional)

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

☐Part time special education paraprofessional
☐Full time special education paraprofessional
☐DeafBlind Intervener
☐Part Time ASL Interpreter
☐Full Time ASL Interpreter
☐Cued Language Transliterator

☐Other (specify) _____

Comment (optional)

Student's Educational Placement *(Check all that apply)*
☐In Home Services
☐Special Education Resource Room- more than 50% of the day
☐Special Education Resource Room- less than 50% of the day
☐Mainstream
☐Pull out Special Education Services
☐Push In Special Education Services
☐Residential School for the Deaf or Blind
☐Other (specify)_____

Comment (optional)

Deaf and Hard of Hearing Service Minutes Per Month

minutes direct service _____

minutes indirect service _____

After completing application form, please mail along with all other required forms to Metro ECSU, Attention: Dolly Carr, 2 Pine Tree Drive, Suite 101, Arden Hills, MN 55112. Questions? Email: gmlaunchpad@metroecsu.org Phone: 612-638-1529.

Once all required documents are received, you will be contacted by the psychologist to discuss scheduling an evaluation.

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The GM Launch PAD program is made possible by a grant from Deaf/Hard of Hearing Services, a division of the Minnesota Department of Human Services.