REFERRAL FOR ILLINOIS DEAFBLIND PROJECT ELIGIBILITY

To process this referral, we request basic demographic and vision/hearing information needed to determine eligibility. The information gathered in other questions help us better serve you. You are welcome to decline answering any question except those designated with an asterisk*. Feel free to contact project staff with concerns regarding privacy or other matters.

Please return this form to:
Philip J. Rock Center & School
818 DuPage Blvd., Glen Ellyn, IL 60137
(630)790-2474
FAX: (630)790-4893
Email: mclyne@philiprockcenter.org

CHILD INFORMATION

Child's Name*

Date of Birth*

Gender

Ethnicity (Hispanic or Not Hispanic)

Race (American Indian or Alaskan Native, Arabic, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, 2 or more, Unknown)

Overall Diagnosis* (if known)

Vision Status*

Date of the most recent vision diagnostic or functional report (please attach or send report) *.

Hearing Status*

Date of the most recent hearing diagnostic or functional report (please attach or send report) *.

Child Address*

City*

State*

Zip*

County*

Is this the parent/guardian address? * Yes/No

FAMILY INFORMATION

Parent/Caregiver #1

Name*

Relationship to Child

Address* (only required if not same as child)

City

State

Zip

County

Phone*

Email*

Primary language*

Parent/Caregiver #2 (if applicable)

Name*

Relationship to Child

Address* (only required if not same as child)

City

State

Zip

County

Phone*

Email*

Primary language*

Is DCFS the legal guardian? *

If yes, **Caseworker Information**

Name*

Address*

City*

State*

Zip*

County*

Phone*

Email*

Primary language*

PROGRAM/SCHOOL INFORMATION

School District or CFC*

Current Attending School (if applicable)*

Program (if applicable)*

Grade*

Program/School Contact Name/Case Manager*

Phone*

Email*

REFERRAL SOURCE INFORMATION

Name of person submitting referral*

Agency (if appropriate) *

Address*

City*

State*

Zip*

Phone*

Email*

How do you know child*?

Date*

How did you find out about Illinois DeafBlind Project services?

Is there anything else that you would like to share about this child?

CONSENT

Parent/Guardian Consent Required

I hereby give permission for this eligibility referral to the Illinois DeafBlind Project. I further understand if my child is found eligible for services, that he/she/they will be included in the Illinois-National Center child count with name and address kept confidential.

I acknowledge and understand that I may revoke consent for this referral at any time, by submitting to Illinois DeafBlind Project a written, signed, and dated notice stating that the consent is revoked.

***Signature of parent or legal guardian**

***Relationship to child**

***Date**

A DeafBlind Specialist will be calling the person making the referral to follow up on this request.
