The Kansas State Deaf-Blind Fund Application Instructions and Forms



Early Childhood, Special Education, and Title Services

An Equal Employment/Educational Opportunity Agency

The Kansas State Department of Education does not discriminate on the basis of race, color, national origin, sex, disability, or age in its programs and activities. The following person has been designated to handle inquiries regarding the non-discrimination policies: The Kansas State Department of Education, 120 SE 10th Ave., Topeka, KS 66612; 785-296-3201.

NOTE: Prior to submitting an application, please review the information contained in *The Kansas State Deaf-Blind Fund Frequently Asked Questions and Answer* document for guidance on how to complete the application and subsequent forms.

The following information includes step-by-step instructions for submitting a Kansas State Deaf-Blind Fund Application. Instructions are provided for each line that needs to be completed on the student's application form. Individual applications for <u>each student</u> need to be submitted. If there are any questions, please call Joan Houghton, EdD 785.296.2515 or <u>jhoughton@ksde.org</u> Cynthia Penrod, 785.296.7454 or <u>cpenrod@ksde.org</u>

It is important to pay attention to the timelines stated in the Question and Answer Document. Timelines for submitting applications are based on priority status and will be followed without exception. Items purchased prior to approval/disapproval become the fiscal responsibility of the applicant.

COVER SHEET

- Write the fiscal year in the spaces provided.
- Write the name of the student in the space provided.
- Write the name of the Part C Infant/Toddler Services, school district, SPED cooperative, or interlocal to receive funding in the space provided.
- Write the address of the Part C Infant/Toddler Services, school district, cooperative, or interlocal in the space provided.
- Write the name of the contact person and telephone number in the space provided.
- Write the fax number and email address of the contact person.
- This sheet needs to be signed and dated by the special education director or designee in the space provided.

STUDENT INFORMATION

- Write the student's name and date of birth in the spaces provided.
- Check yes or no in the space provided to indicate whether the student currently is certified as
 deaf-blind; is transitioning to the home district; is between ages of birth through two years; is a
 student who has a suspected vision loss and documented hearing loss in need of an
 ophthalmological or optometric evaluation; and a student who has a suspected hearing loss and
 documented vision loss in need of an otolaryngological or audiological evaluation.
- Check how the student was counted on the December 1 Child Count in the space provided.
- Provide a description of the student's educational program in the space provided.

FORM A: ASSISTIVE TECHNOLOGY

- Write the student's name in the space provided.
- Write the name of the item, the price (including shipping and handling), and a short instructional rationale describing how the item(s) (based on evidence-based practices) will be used to meet the student's objectives for each item requested in the spaces provided.
- Calculate the amounts (including shipping and handling), and write the total amount in the spaces provided.
- Please note: Insurance for the items that are requested is not covered by The Kansas State Deaf-Blind Fund.
- Attach a catalog or a screen shot picture or written description of each item requested.
 This is required before ANY Kansas State Deaf-Blind Fund Application will be processed.

FORM B: CONSULTANT

- Write the student's name in the space provided.
- Write the consultant's name in the space provided.
- Write a description of the consultant's qualifications in the space provided and attach a resume or vita to the application.
- Write the desired a brief description of the consultation based in evidence-based practices that will be provided for the student. Include for the student in the space provided.
- Estimate consultation fees per day and multiply by the number of days in the space provided.
- Estimate hotel expenses (if applicable) in the space provided.¹
- Estimate mileage (if applicable) in the space provided.
- Estimate meal costs (if applicable) in the space provided.
- Estimate other expenses (if applicable) in the space provided.
- Calculate the total amount requested for the consultant in the space provided.
- Attach a resume or vita of the consultant. This is required before an application for The Kansas State Deaf-Blind Fund will be processed.

FORM C: EVALUATION

- Write the student's name in the space provided.
- Write the evaluator's name in the space provided.
- Write the tentative date of the evaluation in the space provided.
- Write the purpose of the evaluation if it is for an audiology evaluation or an ophthalmological evaluation in the space provided. If the evaluation is for assistive technology, augmentative communication, etc., write the purpose based on evidenced-based practices.
- Calculate the total amount requested for the evaluation in the space provided.
- Attach the name, address location, and service provided by the evaluator. This is required before an application for The Kansas State Deaf-Blind Fund will be processed.

AMENDED FORMS A, B, and C

If the original approved application student is no longer appropriate (e.g., items or services are no longer available), the original application may be amended by submitting one, or more of the amended forms (A: Assistive Technology, B: Consultant, and/or C: Evaluation).

- Write the reason what item is being amended.
- Write the price and the item or services are being requested.
- Submit this information to The Kansas Deaf-Blind Fund Assistant.
- Do not purchase the item or service until the changes have been approved by The Kansas State Deaf-Blind Fund Administrator.

¹ Consultants will be reimbursed by the current state rate for the fiscal year that the application was submitted.

For further information regarding these guidelines or the application process, contact:

Joan Houghton, EdD Kansas State Deaf-Blind Fund Administrator Kansas State Department of Education Early Childhood, Special Education, and Title Services 120 S.E. 10th Avenue

Topeka, Kansas 66612 Phone: 785.296.2515 FAX: 785.296.6715

Email: jhoughton@ksde.org

Cynthia Penrod, Kansas State Deaf-Blind Fund Assistant

Phone: 785.296.7454 FAX: 785.296.6715

Email: cpenrod@ksde.org

THE KANSAS STATE DEAF-BLIND FUND APPLICATION DID YOU REMEMBER TO INCLUDE?

Ch	eck all that apply:
	THE COVER SHEET AND OBTAIN SIGNATURE OF SPECIAL EDUCATION DIRECTOR OR DESIGNEE
	THE STUDENT INFORMATION FORM
	FORM A: INCLUDING PICTURES OF ASSISTIVE TECHNOLOGY OR ADAPTIVE EQUIPMENT REQUESTED
	FORM B: INCLUDING THE CONSULTANT'S RESUME OR CURRICULUM VITA
	FORM C: ATTACH DOCUMENTED VISION OR HEARING LOSS IF REQUESTING SUSPECTED SENSORY LOSS

THE KANSAS STATE DEAF-BLIND FUND COVER SHEET

This application must be completed and submitted by student's local education agency and signed by the Special Education Director or Designee.

al Year:	July 1,	through June 30,		
ne of Stu	udent:			
ne of Pa	rt C Infant/Toddler Services, Sch	nool District, SPED Cooper	ative, or Interl	ocal:
ress:	Street	City	Cooperative, or Interlocal: / State Zip Code phone: / Address: C, Special Education Director, and/ or NE. KSDE USE ONLY.	
tact Per	son:	Telephone:		
#:	of Part C Infant/Toddler Services, School District, SPED Cooperative, or Interlocal:			
	Date		ecial Education	n Director, and/ or
1.				
2.	CONSULTANT (FORM B)			
3.	EVALUATION		\$	
	(FORM C)		Ψ	
	(FORM C) APPROVED ENCUMBE OF THE KANSAS STAT		Ψ	 \$

STUDENT INFORMATION

Student's Name:	DOB:	
Student currently is certified Deaf-Blind by the DB	Project: Yes	No
Student is certified D-B or SID and is transitioning to the student's home district:	Yes	No
Student is between ages of birth – 2:	Yes	No
Student with a suspected vision loss and documen hearing loss in need of an evaluation:	rted Yes	No
Student with a suspected hearing loss and docume vision loss in need of an evaluation:	ented Yes	No
Student is counted in the December 1 Child Count	as: DB SMD Other	
DE	SCRIPTION	
Provide a Short Summary of the Student's Educati	onal Program:	
DISPOSIT	TION OF APPLICATION	
THE FOLLOWING ACTION HAS BEEN TAKEN WITH RESPECT TO	O THIS APPLICATION:	
PARTIAL APPROVAL		
DISAPPROVAL		
SIGNATURE, ADMINISTRATOR, KS STATE DB FUND EARLY CHILDHOOD, SPECIAL EDUCATION, AND TITLE SERVICES KANSAS STATE DEPARTMENT OF EDUCATION	SIGNATURE, STATE ASSISTANT DI EARLY CHILDHOOD, SPECIAL EDU KANSAS STATE DEPARTMENT OF I	CATION, AND TITLE SERVICES
DATE	DATE	
RETURN TO:		
ADMINISTRATOR, THE KANSAS STATE DEAF-BLIND FU KANSAS STATE DEPARTMENT OF EDUCATION EARLY CHILDHOOD, SPECIAL EDUCATION, AND TITLE 120 S.E. 10 TH AVENUE TOPEKA, KS 66612-1182		

FORM A: ASSISTIVE TECHNOLOGY

	Price + Shipping:
	Price + Shipping:
*Instructional Rationale:	
3. Item Name:	Price & Shipping:
4. Item Name: *Instructional Rationale:	
TOTAL TH	IIS PAGE \$
	*Instructional Rationale: *Instructional Rationale: *Instructional Rationale:

FORM B: CONSULTANT

Student's Name:						
Name of C	onsultant:					
Description	Description of Qualifications (attach a resume):					
requested.	of the type of consultation so		·	-		
	days at \$			\$		
Hotel: (at s	state reimbursable rate)		Subtotal	\$		
	Miles (at state reimbursable	rate)	Subtotal	\$		
	Meals (at state reimbursable	e rate)	Subtotal	\$		
Other:			Subtotal	\$		
		L AMOUNT THIS	S PAGE	\$		
consulta	Fees and expenses will be ration was conducted. Please ed costs will be adjusted acco	complete this for				
APPROVA	L			DATE		
FOR KSDE	USE ONLY. APPROVED T	OTAL FOR THIS	PAGE \$			

FORM C: EVALUATION

Student's Name:
Name of the Evaluator:
Tentative Date of the Evaluation:
Purpose of the Evaluation (list either audiological or ophthalmological only; or list type of evaluation (e.g., assistive technology, augmentative communication, etc.) supported by evidenced-based practices.
TOTAL AMOUNT THIS PAGE \$
APPROVAL DATE
FOR KSDE USE ONLY. APPROVED TOTAL FOR THIS PAGE \$

AMENDED FORM A: ASSISTIVE TECHNOLOGY

nended Items oproved	Please list the name, price, and rationale as to why each assistive/instructional technology item for which funding is being amended. Items that are amended must lidentified and supported by evidenced-based practices.			
	1. Item Name:	Price + Shipping:		
		Price + Shipping:		
	3. Item Name:	Price & Shipping:		

FOR KSDE USE ONLY. AMENDED APPROVED TOTAL FOR THIS PAGE \$_____

AMENDED FORM B: CONSULTANT

Student's Name:		
Name of Consultant:		
•	•	<u> </u>
Miles (at state reimbursable rate) Meals (at state reimbursable rate) Subtotal \$ Subtotal \$ TOTAL AMMENDED AMOUNT THIS PAGE *NOTE: Fees and expenses will be reimbursed at the state reimbursable rate. Please identify the item that is being amended. It may not exceed the amount from the original application. estimated		
Hotel: (at state reimbursable rate)	Subtotal \$	
Miles (at state reimbursable rate) Subtotal \$	
Meals (at state reimbursable rate	e) Subtotal \$	·
Other:	Subtotal \$	·
TOTAL AMMENDED AN	MOUNT THIS PAGE	\$
APPROVAL		DATE

FOR KSDE USE ONLY. AMENDED APPROVED TOTAL FOR THIS PAGE \$____

AMENDED FORM C: EVALUATION

Student's Name:
Name of the Evaluator:
Tentative Date of the Evaluation:
Purpose of the Evaluation (list either audiological or ophthalmological only; or list type of evaluation (e.g., assistive technology, augmentative communication, etc.) supported by evidenced-based practices.).
TOTAL AMENDED AMOUNT THIS PAGE \$
APPROVAL DATE
FOR KSDE USE ONLY. AMENDED APPROVED TOTAL FOR THIS PAGE \$

THE KANSAS STATE DEAF-BLIND FUND REQUEST FOR REIMBURSEMENT FY 2013-2014

INSTRUCTIONS: Please complete all information as requested. Submit documentation of expenditures (invoices or receipts required) with this form.

	TAX ID NUMBER (FEIN)			
ADDRESS:	OLTY	OT A TE	710 000	
	CITY	STATE	ZIP CODE	
CONTACT PERSON:	PHONE NUMBER	FAX	NUMBER	
	EMAIL ADDRESS			
STUDENT:				
	BIRTHDATE			
EXPENDITURES:				
ASSISTIVE TECHNOLOGY				
CONSULTANT				
EVALUATION				
GRAND TOTAL				
REMARKS:				
SIGNED:				
SPECIAL EDUCATION DIRECTOR/DESIGNEE		DATE		
APPROVAL:				
ADMINSTRATOR, THE KANSAS STATE DEAF-BLIND FUND		DA	TE	

Submit the application, documentation, supplemental, and/or reimbursement information to:

Joan Houghton, EdD
Administrator, The Kansas State Deaf-Blind Fund
Kansas State Department of Education
Early Childhood, Special Education, and Title Services
120 S.E. 10th Avenue
Topeka, KS 66612
Phone: 785.296.2515 (V/TTY)
FAX: 785.296.6715

Email: jhoughton@ksde.org

Cynthia Penrod,
Assistant, The Kansas State Deaf-Blind Fund
Kansas State Department of Education
Early Childhood, Special Education, and Title Services
120 S.E. 10th Avenue
Topeka, KS 66612
Phone: 785.296.7453

FAX: 785.296.6715 Email: cpenrod@ksde.org