Project DOVES – Delivering Optimal Vision Education Services
Participation Agreement 2015–2016

As a part of the Regional Plan for Services to Students with Visual Impairments (VI), up to 100 students may receive a low vision evaluation from the University of Houston’s Center for Sight Enhancement and the prescribed device(s) within the limits of the program. Teachers must apply on behalf of their student and be selected by Region 4 Education Service Center (Region 4) as one of the participants. Signatures of the Special Education Director or Supervisor, Teacher of Students with Visual Impairments (TVI) and the Certified Orientation and Mobility Specialist (COMS) are a requirement of this agreement. Students who have participated may not participate again for three years. Special circumstances that warrant a new examination will be considered on a case-by-case basis.

Required Documents
- Signed Project DOVES Participation Agreement Form 2015–2016 (page 2)
- Signed Project DOVES Parent/Guardian Consent Form (page 3)
- Completed Project DOVES Student Information Form (pages 4 and 5)
- Completed Project DOVES Checklist Form (page 6)
- Current (within 3 years) Functional Vision Evaluation and Learning Media Assessment report
- Most current eye report
- Orientation and Mobility (O&M) evaluation report or an explanation of non-need for O&M services

Criteria
Students must meet all three of the following criteria:
- Currently identified as having a visual impairment, and
- Staff has identified concerns regarding visual functioning in the educational setting, and
- Will likely benefit from an optical device.

District Responsibilities
- Schedule the low vision evaluation with the clinic and the student’s family by May 2, 2016. (The appointment does not need to be completed by this date.)
- Ensure that certified personnel participating in the project attend with each student the low vision evaluation, follow-up examinations and training.
- Provide interpreters as needed by the student or family (sign language or foreign language).
- Instruct the student in the use of any prescribed optical device.
- Provide the doctor and Region 4 with a Project DOVES Follow-up Report (page 7) stating what works and/or does not work within **60 days** after the examination. Indicate if a follow-up visit will be necessary.

Region 4 Responsibilities
- Provide funding for the low vision evaluation and prescribed optical device up to the predetermined amount.
- Provide ongoing training and technical support for the TVI or COMS who will instruct the student in the use of the prescribed device.

Project DOVES Contact Information
- Sheryl Sokoloski 713.744.6315 or sheryl.sokoloski@esc4.net or fax 713.744.6811
- Cecilia Robinson 713.744.6379 or cecilia.robinson@esc4.net
- Center for Sight Enhancement 713.743.0799 or fax 713.743.0190
Project DOVES
Participation Agreement Form 2015–2016

Please sign and return this page to indicate acceptance of terms as stated in page 1 of the Project DOVES Participation Agreement 2015–2016.

Return to:

Sheryl Sokoloski
Region 4 Education Service Center
7145 West Tidwell, Houston, TX 77092
e-mail: sheryl.sokoloski@esc4.net

*Fax: 713.744.6811 Prior to faxing, please contact Sheryl Sokoloski so that the application can be secured when received.

____________________________________________________________________________________

Student Name

____________________________________________________________________________________

School District

____________________________________________________________________________________

Predominant language spoken at home

____________________________________________________________________________________

Required Signatures (TVI and COMS currently serving the student):

Teacher of Students with Visual Impairments E-mail Phone

Certified Orientation and Mobility Specialist E-mail Phone

Special Education Administrator (Please Print) Signature

Date__________________________________
Parent/Guardian Consent Form

Student: ________________________________________________________________

Parents/Guardian must agree to the following Project DOVES guidelines:

1. Grant permission for my child to participate in Project DOVES.

2. Grant permission for my child’s eye examination report to be released to Region 4 Education Service Center and The University of Houston Center for Sight Enhancement for use during the low vision evaluation.

3. Ensure that adult family member(s)/guardian confer with certified school personnel about scheduling the appointment with the Center for Sight Enhancement.

4. Ensure that adult family member(s)/guardian will transport and accompany my child to the Center for Sight Enhancement for initial and follow-up visits:

   University of Houston, Center for Sight Enhancement
   505 J. Davis Armistead Building
   4901 Calhoun Road, Houston, Texas 77204
   Phone: 713.743.2020

5. Ensure completion of all evaluations and follow-up visits required by Project DOVES and the Center for Sight Enhancement.

6. Ensure that device(s) prescribed will be available for use at school during school hours.

________________________________________________________________________
Signature of Parent/Guardian _____________________________________________ Date

________________________________________________________________________
Address/City/Zip

________________________________________________________________________
Daytime Phone Number ____________________________________________ E-mail

Medicaid benefits available Yes No
Project DOVES

Student Information Form (pages 4-5)

Today's Date: __________________ Person completing form: ________________________________

Name: ____________________________ DOB: ____________________________

Address: ____________________________ Telephone: ____________________________

Visual Diagnosis: ____________________________

Prognosis: ____________________________ Date of last Eye Exam: __________

Age at Onset: __________ Primary Eye Care Practitioner: ____________________________

Other Impairments: ____________________________

Medications: ____________________________

Educational Setting: (circle all that apply) General Education Homebound Resource Self-Contained Life Skills PPCD Pre-K Other________

Is the student verbal? Yes  No Primary language ____________________________

If no, how does the student communicate? ____________________________

Is the student reading at grade level? Yes  No  If no, what is the reading level? __________

1. What are the academic visual tasks that the student is unable to perform?
   a. student’s perspective ____________________________
   b. teacher’s perspective ____________________________
   c. parent’s perspective ____________________________

2. Additional comments/concerns/information/student behavior(s) you want the doctor to know:

3. What are the expectations that you would like to share with the doctor? (e.g., for the exam, for the outcome in school, for meeting visual goals stated in the IEP etc.)

4. What are the areas of difficulty? Include tasks in both the TEKS and Expanded Core Curriculum. For example, computers, electronic texts, print, travel, etc. **Bring to the evaluation samples of the materials used by the student.

5. What type of traveler is the student? (circle all that apply)
   independent traveler  route traveler  guide cane  non-traveler  public transportation

6. Is he/she proficient in familiar/unfamiliar environments when traveling? (specify)
Prior Low Vision Evaluation: Yes______ No______ If yes, date of evaluation:______________

- Please check off any **prescribed optical device(s)**
- **Indicate** if the optical device is currently in use
- **Specify** if the staff has received training on the optical device and how to support the student

### Near Devices

<table>
<thead>
<tr>
<th>Device</th>
<th>Yes</th>
<th>No</th>
<th>Staff received training? Yes, No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand-held magnifier</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stand magnifier</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Reading glasses/microscope</td>
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<tr>
<td>Video magnifier (stand-alone, hand-held)</td>
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<tr>
<td>Bifocals</td>
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<td></td>
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<tr>
<td>Other</td>
<td></td>
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<td></td>
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</tbody>
</table>

### Distance Devices

<table>
<thead>
<tr>
<th>Device</th>
<th>Yes</th>
<th>No</th>
<th>Staff received training? Yes, No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telescope</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Prisms</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Contact lenses</td>
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<tr>
<td>Glasses</td>
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<td></td>
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<tr>
<td>Filters</td>
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<td></td>
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<tr>
<td>Sunglasses</td>
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<td></td>
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<tr>
<td>Other</td>
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</tbody>
</table>
Project DOVES

Checklist Form

Student: ______________________________ District: __________________________ Date: __________
TVI: ________________________________ COMS: ______________________________

☐ Project DOVES Checklist Form: Completed (page 6)
☐ Project DOVES Participation Agreement Form: Completed and signed (page 2)
☐ Project DOVES Parent Consent Form: Completed and signed (page 3)
☐ Project DOVES Student Information Form: Completed (pages 4 and 5)

☐ Most recent eye report attached Report Date: ________________
☐ Functional Vision Evaluation attached Report Date: ________________
☐ Learning Media Assessment attached Report Date: ________________
☐ Orientation and Mobility Evaluation (or explanation of non-need for O&M) Report Date: ________________
Explanations_______________________________________________________________________

☐ Special request by ARD committee, if not recommended in FVE/LMA. Copy of minutes from ARD meeting recommending a low vision evaluation is attached.

Evaluation choice
☐ Low vision evaluation
☐ Low vision evaluation for students who are non-verbal or students with multiple and visual impairments

Reminder
• Complete Project DOVES Follow-up Report Form (page 7) approximately 60 days after the low vision evaluation.
• Write a brief report telling the doctor how successful/unsuccesful the student has been as a result of the low vision evaluation, and whether a follow-up appointment is needed.
• Fax the report to the attention of the doctor who conducted the evaluation at the Center for Sight Enhancement. Fax: 713.743.0190
• Fax a copy of the report to Region 4, Fax: 713.744.6811, attention, Sheryl Sokoloski
Project DOVES

Follow-up Report Form
(Must be submitted within 60 days.)

Student:__________________________ District:________________ Date:_____________

TVI:_____________________________ COMS:_____________________________

Date of Evaluation:_______________ Low Vision Doctor:_______________________

Purpose of the Low Vision Evaluation, please specify:

<table>
<thead>
<tr>
<th>Prescribed Optical Devices</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Near Device(s)</td>
<td>In Use</td>
<td>Frequency</td>
<td>Comments</td>
</tr>
<tr>
<td>Distance Device(s)</td>
<td>In Use</td>
<td>Frequency</td>
<td>Comments</td>
</tr>
<tr>
<td>Glasses</td>
<td>In Use</td>
<td>Frequency</td>
<td>Comments</td>
</tr>
</tbody>
</table>

1. Were new IEP goals needed, and if so, written for device training?

2. Who provides the training for the student on the new device(s)?

3. What changes do you see for your student as a result of the information obtained during the low vision evaluation?

4. Indicate what is working and/or not working for the student.

5. Is a follow-up appointment needed at this time? _______Yes _______No

**Fax** a copy to the attention of the doctor who conducted the examination at the **Center for Sight Enhancement**. Fax: 713.743.0190

**Fax** a copy of the report to **Region 4**, Fax: 713.744.6811, attention, Sheryl Sokoloski or e-mail sheryl.sokoloski@esc4.net