



Project DOVES

Delivering Optimal Vision Education Services **Participation Agreement 2019-2020**

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 2018-2019 (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 as to why services are not needed

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 1, 2020 (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
- Center for Sight Enhancement 713.743.0799 or fax 713.743.0190



Project DOVES

Participation Agreement Form 2019-2020

Please sign and return this page to indicate acceptance of terms as stated in page 1 of the Project DOVES Participation Agreement 2019-2020.

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: _____

Campus Name: _____

Predominant Language Spoken at Home: _____

Required Signatures:

| | | |
|---|--------|-------|
| Signature - Teacher of Students with VI | E-mail | Phone |
|---|--------|-------|

| | | |
|---|--------|-------|
| Signature - Certified Orientation and Mobility Specialist | E-mail | Phone |
|---|--------|-------|

| | | |
|---|--------|-------|
| Signature - Special Education Administrator | E-mail | Phone |
|---|--------|-------|



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.

Teacher of Students with VI

Phone

E-mail

Note: TVI **MUST** complete the information above prior to giving this form to the parent/guardian.

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.
7. What are the visual concerns for your child: _____

Signature of Parent/Guardian

Date

Address/City/Zip

Daytime Phone

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:

- Is the student verbal? Yes ___ No ___ Primary language: _____
- If student is non-verbal, how does the student communicate: _____
- Is the student reading at grade level: Yes ___ No ___
- If no, what is the student's reading level: _____

1. What are the academic visual tasks that the student is unable to perform:
 - a. student's perspective: _____
 - b. teacher'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 school, for meeting visual goals 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) _____



Project DOVES

Student Information Form (pages 4-5) continued

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 | YES | NO | Has Staff Received Training? | |
|--|-----|----|------------------------------|----|
| | | | YES | NO |
| Hand-held magnifier | | | | |
| Stand magnifier | | | | |
| Reading glasses/microscope | | | | |
| Video magnifier (stand-alone, hand-held) | | | | |
| Bifocals | | | | |
| Other | | | | |

| Distance Devices | YES | NO | Has Staff Received Training? | |
|------------------|-----|----|------------------------------|----|
| | | | YES | NO |
| Telescope | | | | |
| Prisms | | | | |
| Contact lenses | | | | |
| Glasses | | | | |
| Filters | | | | |
| Sunglasses | | | | |
| Other | | | | |



Project DOVES

Checklist Form 2019-2020

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 & 5)
- Most recent eye report attached Report Date: _____
- Functional Vision Evaluation attached Report Date: _____
- Learning Media Assessment attached Report Date: _____
- Orientation and Mobility Evaluation Report Date: _____
(or explanation of non-need for O&M)
Explanation _____
- 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

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

Prescribed Optical Devices

| Near Device(s) | In Use | Frequency | Comments |
|--------------------|--------|-----------|----------|
| | | | |
| | | | |
| Distance Device(s) | In Use | Frequency | Comments |
| | | | |
| | | | |
| Glasses | In Use | Frequency | Comments |
| | | | |

1. Were new IEP goals needed, and if so, were they 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