Project DOVES

Delivering Optimal Vision Evaluation Services

Participation Agreement 2020-2021

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 2020-2021(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, 2021

  (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
- Center for Sight Enhancement 713.743.0799 or fax 713.743.0190

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Participation Agreement Form 2020-2021

Please sign and return this page to indicate acceptance of terms as stated in page 1 of the Project DOVES Participation Agreement 2020-2021.

Return to: Sheryl Sokoloski
Region 4 Education Service Center
7145 West Tidwell, Houston, TX 77092

E-mail: sheryl.sokoloski@esc4.net

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

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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 which may include a Telehealth option 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 ☐

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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) _____

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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				

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Checklist Form
2020-2021

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. Email a copy of the report to **Region 4**, **Sheryl.Sokoloski@esc4.net**

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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

Email a copy to Region 4, sheryl.sokoloski@esc4.net