IDAHO PROJECT FOR
CHILDREN AND YOUTH
WITH DEAF-BLINDNESS

TECHNICAL ASSISTANCE REQUEST FORM
(Parents)

Date of Request: _____

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Email: _____

Child's Name: _____ Date of Birth: _____

What Type of Technical Assistance Would be Helpful to You? (select all that apply)

Training ☐ Phone Contact ☐ School Visit ☐ Information/Resources ☐

How do you prefer to be contacted? (select all that apply)

Phone ☐ Email ☐

When is a good time to contact you?

Day _____ Time_____

What Topics Would You Like to Address? (Please check the appropriate box)	
Help in designing a communication system for a child	☐
Help in planning for a transition (e.g., early intervention to preschool, elementary to middle school or high school to adult services)	☐
Additional information about deaf-blindness and a child's combined vision and hearing loss	☐
Ideas for handling challenging behaviors	☐
Help with developing a child's IEP or IFSP	☐
Ideas on how to involve a child with other children	☐
How I might use assistive technology (e.g., switches) with a child	☐
Other (please specify):	☐

Please provide a brief comment about why you are making this request:
