



# PROJECT REACH: Illinois Deaf-Blind Services

*Serving youth who are deaf-blind, their families,  
and their schools*

Please return this form to:  
Philip J. Rock Center & School  
818 DuPage Blvd., Glen Ellyn, IL 60137  
(630)790-2474/(800)771-1158  
TTY: (800)771-1232/FAX: (630)790-4893  
Email: [PRC@aol.com](mailto:PRC@aol.com)

**FORM A: INITIAL REFERRAL FOR DETERMINATION OF  
ELIGIBILITY FOR SERVICES**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ County: \_\_\_\_\_

School District/CFC: \_\_\_\_\_ Current Program/School: \_\_\_\_\_

Current Program Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Parent(s)/Caregiver(s) Name(s): \_\_\_\_\_

Mother

Father

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

(if different from above)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Primary language used in home: \_\_\_\_\_

Is there a legal guardian other than parents?  Yes  No

If yes... \_\_\_\_\_

Name

Address

City

State

Zip

Phone Number

Cause of Deaf-Blindness (if known): \_\_\_\_\_

\* Vision Status (if known): \_\_\_\_\_

\* Hearing Status (if known): \_\_\_\_\_

\* \_\_\_\_\_ Please attach the most recent vision and hearing  
diagnostic reports

Name of person submitting referral: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

How do you know child? \_\_\_\_\_

What do you need help with? \_\_\_\_\_

Is there anything else you would like for us to know? \_\_\_\_\_

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*A Deaf-Blind Specialist will be calling you to follow up on this request.*