#### Kansas Deaf-Blind Project Logo

#### AGENCY REQUEST FOR CONSULTATION

***State deaf-blind projects have permission to adapt this tool for use by their own projects. Please include appropriate citation information. For example, "Adapted with permission from [document name, state deaf-blind project name, date (if available)]."***

Date of Application: Phone:

School/District Name: Fax:

Contact Person: Position:

Address: E-mail:

In order to effectively meet your technical assistance needs, please complete the following:

1. **We are requesting technical assistance/consultation to improve:**
2. **Is this child listed on the Deaf Blind Census?**
3. **Describe the type of help you are requesting:**
4. **What do you hope to achieve from this consultation? Describe the desired outcome(s) of the consultation:**
5. **Describe your school setting, size, grade levels, student population, etc. If requesting an individual student consultation, please describe the student’s age, sex, disability(ies), school placement/setting, and grade level:**
6. **When would you like assistance? List preferred dates, days of the week, and times for assistance**:
7. **Other relevant information**:

*Contact Person Signature:*

*Administrator Signature:*

1.5.15