

Missouri Commission for the Deaf and Hard of Hearing

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Census of Persons with Hearing Loss

Section 161.407 of the Revised Statutes of Missouri requires the Missouri Commission for the Deaf and Hard of Hearing to conduct and maintain a census of Missouri citizens who have a hearing loss. **All information provided to the Commission on a census form will be held strictly confidential**, and the Commission will never reveal the identity of any person who fills out a census form. Please mail this completed form to the address given above or fax it to the fax number given above. If you have any questions about this form, please contact our office between 8:00 am and 4:30 pm, Monday through Friday.

Please Print Clearly

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Social Security #: _____ E-Mail Address: _____

FAX #: _____ Phone #: _____ (V/TTY/Both)

Videophone #: _____ Pager Address: _____

Do you consider yourself: *Culturally Deaf* *Hard of Hearing* *Late Deafened* *Oral Deaf*
 Other (Specify): _____

Your approximate age when your hearing loss started: *Birth* (or) _____ *Years Old*

Cause of your hearing loss (if known):

- | | | | |
|-------------------------------------------------|--------------------------------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> <i>Aging</i> | <input type="checkbox"/> <i>Head Trauma</i> | <input type="checkbox"/> <i>Heredity</i> | <input type="checkbox"/> <i>High Fever</i> |
| <input type="checkbox"/> <i>Infection</i> | <input type="checkbox"/> <i>Measles</i> | <input type="checkbox"/> <i>Meningitis</i> | <input type="checkbox"/> <i>Mumps</i> |
| <input type="checkbox"/> <i>Noise Exposure</i> | <input type="checkbox"/> <i>Otitis Media</i> | <input type="checkbox"/> <i>Otosclerosis</i> | <input type="checkbox"/> <i>Ototoxic Drug</i> |
| <input type="checkbox"/> <i>Premature Birth</i> | <input type="checkbox"/> <i>Rh Incompatibility</i> | <input type="checkbox"/> <i>Rubella</i> | <input type="checkbox"/> <i>Surgery</i> |
| <input type="checkbox"/> <i>Trauma at Birth</i> | <input type="checkbox"/> <i>Other (Specify):</i> _____ | | |

Do you communicate using sign language? *Yes* *No*

Do you have a cochlear implant? *Yes* *No*

Do you use a hearing aid? *Yes* *No*

If "Yes," what type of hearing aid? *Behind-The-Ear* *In-The-Ear* *In-The-Canal*

Would you like to receive the MCDHH e-news digest and announcements via e-mail? *Yes* *No*

(Rev 12/20/11)