Department of Employment, Training & Rehabilitation

BUREAU OF SERVICES TO THE BLIND AND VISUALLY IMPAIRED

**APPLICATION FOR:  
 OLDER INDIVIDUALS WHO ARE BLIND PROGRAM**

NAME:

*First Initial Last*

ADDRESS:

CITY: STATE: ZIP:

TELEPHONE:

*Home Contact*

SSN: DOB:

**VOTER REGISTRATION**

❒Registered ❒Not currently registered



❒ MALE ❒ FEMALE

RACE: MARITAL STATUS:

VISION PROBLEM:

DATE OF ONSET:

HAVE YOU APPLIED FOR REHABILITATION/LOW VISION SERVICES BEFORE? ❒YES ❒NO

IFYES, WHERE? WHEN?

HOW WERE YOU REFERRED TO BSBVI?

HOW CAN BSBVI HELP YOU?

DO YOU CURRENTLY DRIVE? ❒YES ❒NO

TRANSPORTATION YOU RELY ON AT THIS TIME:

**WHO TO CONTACT IN CASE OF EMERGENCY:**

NAME:

*RELATIONSHIP*

ADDRESS:

PHONE:

**HOUSEHOLD MEMBERS**

NAME AGE RELATIONSHIP OCCUPATION

**EDUCATION:**

HIGHEST LEVEL OF EDUCATION:

PAST PROFESSION(S):

REASON LEFT:

ARE YOU INTERESTED IN EMPLOYMENT? ❒YES ❒NO

ARE YOU A VETERAN? ❒YES ❒NO

DO YOU HAVE PRIVATE INSURANCE? ❒YES ❒NO

NAME OF INSURANCE:

DO YOU HAVE MEDICARE INSURANCE? ❒YES ❒NO

❒PART A ❒PART B ❒BOTH

DO YOU HAVE MEDICAID COVERAGE? ❒YES ❒NO

Notes:

**ATTACHMENT TO APPLICATION**   
*Confidential Personal Information*

* I understand that it is necessary for the Bureau to collect personal information in connection with the Older Independent Blind (OIB) program.
* I understand such information will be collected, to the maximum extent practicable, from me.
* All information provided by me will be held confidential and will be used only in connection with the (OIB) program.
* I understand that all information is available to me when requested in writing, except where the Bureau believes such information can reasonably be expected to cause serious physical or emotional harm.
  + In this instance, the Bureau shall release such information to an authorized representative.
* I understand that information will not be re-disclosed to any other person or entity except
  + when a properly signed Release of Information form, conditioned and dated, is presented or
  + in the direct administration of the (OIB) program as defined in the Confidentiality Policy (Section 130.1, BVR/BSBVI Policy and Procedures Manual).
  + Records maintained by the federal Rehabilitation Services Administration do not identify me (RSA-PD-91-12).

**Prior Authorization Statement**

* I understand the Bureau of Services to the Blind & Visually Impaired will not pay for any service which my counselor HAS NOT AUTHORIZED IN WRITING.
* If my counselor approves a medical examination, this is NOT approval for my treatment or surgery.
* When a doctor, hospital, merchant of other vendor has not received advance approval from my counselor, I understand I will have to pay for any goods or services myself.

**Client Financial Participation**

* I understand that I will be asked to furnish financial information and my financial need will be considered in determining my participation in the cost of the (OIB) program services which require the expenditure of case service dollars.
* I will not be required to participate in the cost of diagnostic services to evaluate my rehabilitation potential, counseling, guidance and referral services, or placement services.

**The Client Assistance Program (CAP)**

* The CAP can provide you information and assistance regarding the programs and services offered by Bureau.
* CAP can explain available services, investigate any concerns you may have and assist you to resolve your concerns.
* You may contact the CAP office closest to your location:

**Southern Office** **Northern Office** **Elko Office**

2820 W Charleston Blvd, Ste 11 1875 Plumas St., Ste 1 905 Railroad St, Ste 104B

Las Vegas, NV 89102 Reno, NV 89509 Elko, NV 89801

Phone: 702-257-5120 Phone: 775-333-7878 Phone: 775-777-1590

Toll Free: 1-888-349-3843 Toll Free: 1-800-992-5715 Toll Free:1-800-992-5715

Nevada Relay: 711 Nevada Relay: 711 Nevada Relay: 711

[lasvegas@ndalc.org](mailto:lasvegas@ndalc.org) [reno@ndalc.org](mailto:reno@ndalc.org) [elko@ndalc.org](mailto:elko@ndalc.org)

**Review of Disagreements:  
 Regarding the Furnishing or Denial of Services**

* If you disagree with a decision made by your (OIB) program counselor concerning the furnishing or denial of services, you have the right to have that decision reviewed.
* First, you should talk to your counselor or the counselor's supervisor about your concerns.
* Next, you can contact the Client Assistance Program (CAP) to assist you with the review process.
* You have the right to request a formal review of your dissatisfaction with a decision regarding the furnishing or denial of services.
* The review will be conducted by an impartial hearings officer.
  + You must request a hearing in writing.
  + You must state in your request the action(s) with which you are dissatisfied.
  + You must send your written request to the Chief of the Rehabilitation Division, 1370 South Curry Street, Carson City, Nevada 89703.
* Any scheduled hearing will be held within 60 days of your request.



* I HAVE BEEN ADVISED OF THE PROTECTION, USE AND RELEASE OF PERSONAL INFORMATION.
* I HAVE BEEN ADVISED OF THE CLIENT ASSISTANCE PROGRAM.

I HAVE BEEN ADVISED OF MY OPPORTUNITY FOR REVIEW OF DECISIONS MADE BY MY REHABILITATION COUNSELOR REGARDING THE FURNISHING OR DENIAL OF SERVICES.



SIGNATURE DATE

SIGNATURE IF APPLICANT NEEDED ASSISTANCE WITH APPLICATION:



SIGNATURE DATE

Department of Employment, Training & Rehabilitation

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| --- |
| **HEALTH SURVEY** |

Please complete this health survey as completely as possible. This survey will give your counselor an overview of your current health and medical background. If you need more space, or would like to remark, please use the bottom of this form.

DATE: NAME:

**VISION**

DESCRIBE YOUR VISION:

WHEN DID YOU FIRST EXPERIENCE THIS VISION LOSS?

HOW DOES YOUR VISION LOSS LIMIT WHAT YOU CAN DO AROUND THE HOME?

WHAT IS THE NAME OF YOUR EYE DOCTOR?

WHAT TREATMENT HAVE YOU RECEIVED FOR YOUR VISION LOSS?

WHAT WAS THE DATE OF YOUR LAST VISIT TO THE EYE DOCTOR?

TELL ME ABOUT YOUR DISTANCE VISION:

TELL ME ABOUT YOUR READING VISION:

DO YOU USE ANY SPECIAL EQUIPMENT? *(EXAMPLES: MAGNIFIERS, CCTV, WRITING GUIDES, TALKING CALCULATORS, BOLD LINE PAPER, ELECTRONIC NOTE TAKERS, LARGE BUTTON TELEPHONE AND WATCH?)*:

CAN YOU SEE COLORS? ❒YES ❒NO

IF SO, WHICH COLORS DO YOU SEE BEST?

**MEDICAL HISTORY**

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

❒HEARING ❒HIGH BLOOD PRESURE ❒CANCER  
❒MENTAL HEALTH**\***

***\*****Includes learning, thinking, processing information & concentration. Psychosocial, interpersonal and behavioral, coping, stress or Alzheimer’s, ETC.*

❒CARDIAC & CONDITIONS OF THE CIRCULATORY SYSTEM   
❒DIABETES MELLITUS ❒END STAGE RENAL DISEASE  
❒MUSCULOSKELETAL**\***

**\****Arthritis, rheumatism, amputations, fractures/injuries which resulted in permanent loss*/*impairments* *of limb function*.

❒NEUROLOGICAL impairments/disorders due to: stroke, diabetes neuropathy, Parkinson’s disease, seizure disorders, multiple sclerosis, etc.  
❒RESPIRATORY OR LUNG CONDITIONS ❒OTHER

COMMENTS:



SIGNATURE DATE

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SIGNATURE DATE

