

State of Nevada

Department of Employment, Training & Rehabilitation BUREAU OF SERVICES TO THE BLIND AND VISUALLY IMPAIRED

APPLICATION FOR: OLDER INDIVIDUALS WHO ARE BLIND PROGRAM		
NAME:		
<i>First</i>	<i>Initial</i>	<i>Last</i>
ADDRESS:		
CITY:	STATE:	ZIP:
TELEPHONE:		
<i>Home</i>	<i>Contact</i>	
SSN:	DOB:	

VOTER REGISTRATION

Registered

Not currently registered

MALE

FEMALE

RACE:	MARITAL STATUS:
VISION PROBLEM:	
DATE OF ONSET:	

State of Nevada

HAVE YOU APPLIED FOR REHABILITATION/LOW VISION SERVICES BEFORE?

YES NO

IF YES, 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

State of Nevada

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:

State of Nevada

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.

State of Nevada

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

2820 W. Charleston Blvd. #11
Las Vegas, NV 89102
Phone: 702-257-5120
Toll Free: 1-888-349-3843
Nevada Relay: 711
lasvegas@ndalc.org

Northern Office

1875 Plumas Street #1
Reno, NV 89509
Phone: 775-333-7878
Toll Free: 1-800-992-5715
Nevada Relay: 711
reno@ndalc.org

Elko Office

905 Railroad St, Ste 104B
Elko, NV 89801
Phone: 775-777-1590
Toll Free: 1-800-992-5715
Nevada Relay: 711
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.

State of Nevada

- 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.
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- 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

State of Nevada

Department of Employment, Training & Rehabilitation
BUREAU OF SERVICES TO THE BLIND AND VISUALLY IMPAIRED

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?

State of Nevada

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?

State of Nevada
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

SIGNATURE IF APPLICANT NEEDED ASSISTANCE WITH APPLICATION:

SIGNATURE DATE