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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-22468 (07/2016) | | |  | | | | **STATE OF WISCONSIN** | | | |
| APPLICATION FOR SERVICES WITH THE  OFFICE FOR THE BLIND AND VISUALLY IMPAIRED | | | | | | | | | | |
| **INSTRUCTIONS: Complete and sign this form. Completion of this form is voluntary. Personally identifiable information collected on this form is confidential and will only be used in determining eligibility for services.** | | | | | | | | | | |
| **Name – Consumer Last** | | | **First** | | | | | | | **M.I.** |
| **Street or P.O. Box** | | | | | **Apartment Number** | | | | | |
| **City** | | | **Zip Code** | | **County** | | | | | |
| **Telephone Number (Include Area Code)** | | | | | | | | | | |
| **Email Address** | | | | | | | | | | |
| **Birthdate (mm/dd/yyyy)** | | **Sex**  **Male**  **Female** | | | | | | | **Date of Onset** | |
| **Race / Ethnicity** | | | | **Highest Level of Education** | | | | | | |
| **Source of Referral** | | | | **Marital Status** | | | | | | |
| Alternate Contact Person Section | | | | | | | | | | |
| **Name – Alternate Contact** | | | | **Relationship** | | | | | | |
| **Telephone Number** | | | | | | | | | | |
| **List your type of residence (e.g., house, apartment, assisted living facility, nursing home)** | | | | | | | | | | |
| **Do you live alone or with others? Live Alone**  **With Others** | | | | | | | | | | |
| **Are you a U.S. Veteran? Yes**  **No** | | | | | | | | | | |
| **What is your visual impairment?** | | | | | | | | | | |
| How does your visual impairment impact your ability to complete daily living tasks/activities? | | | | | | | | | | |
| **Name – Eye Doctor** | | | | | | **Date of Last Exam** | | | | |
| **Please list any other concerns or conditions.** | | | | | | | | | | |
|  | | | | | | | | | | |
| **X** | **SIGNATURE – Consumer / Representative** | | | | | | | **Date Signed** | | |