|  |  |  |
| --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-22468 (07/2016) |  | **STATE OF WISCONSIN** |
| APPLICATION FOR SERVICES WITH THEOFFICE 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**      |