MISSOURI DIVISION OF SOCIAL SERVICES
BUREAU FOR THE BLIND

REHABILITATION OF THE BLIND APPLICATION

APPLICANT NAME (LAST, FIRST, MIDDLE)

I, , HEREBY APPLY FOR SERVICES

☐ VOCATIONAL REHABILITATION ☐ INDEPENDENT LIVING REHABILITATION

Administered by the Bureau for the Blind, Missouri Division of Family Services.

APPLICANT ADDRESS (STREET, P.O. BOX NO., RFD NO., CITY, STATE, ZIP CODE)

DIRECTIONS TO HOME

Services administered by the Bureau for the Blind, Missouri Division of Family Services, are in compliance with the Civil Rights Act of 1964 and/or Section 504 of the Rehabilitation Act of 1973, as amended.

Discrimination against any person on the basis of race, national origin, religion, political preference, or handicapping condition is prohibited.

All information given by me to a representative of the Bureau for the Blind is confidential and may be used only for the purpose of carrying out my rehabilitation program, except in situations where Federal or State laws take precedence over the Rehabilitation Act of 1973.

The provision of services is dependent upon my eligibility for the services and upon the availability of Federal and State funds to meet the cost of services. I agree to have the necessary eye and/or medical examinations so that my eligibility for services can be determined.

I have the right of appeal if my application is denied or if it is not acted upon promptly.

I can obtain further information on my rights to appeal by contacting the Bureau representative whose name, address, and telephone number are shown below.

MISSOURI BUREAU FOR THE BLIND

ATTN Bureau Representative ▶

SIGNATURE OF APPLICANT DATE

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Missouri Protection and Advocacy Services operates a Client Assistant Program which may be of interest and help to you. The Client Assistance Program provides several services including assistance in pursuing legal, administrative, or other solutions to protect your rights under the Rehabilitation Act of 1973, as amended. They also provide information about other agencies and programs in Missouri which offer rehabilitation services to persons with disabilities.

You may contact the Client Assistance Program by writing or telephoning:

Missouri Protection and Advocacy Services
211B Metro Drive
Jefferson City, Missouri 65101

Telephone: 1-800/392-8667

MISSOURI DIVISION OF FAMILY SERVICES
BUREAU OF THE BLIND
CLIENT DATA RECORD

SECTION I PERSONAL AND STATISTICAL INFORMATION

CLIENT'S NAME (LAST, FIRST, MIDDLE)			CASE NUMBER
ADDRESS (STREET P.O. BOX NO., RFD NO.)			COUNTY
CITY	STATE	ZIP CODE	PHONE NUMBER
DATE OF BIRTH	SEX	MARITAL STATUS	RACE
DATE OF REFERRAL	METHOD OF REFERRAL		INFORMATION RECORDED BY
REFERRAL SOURCE	ADDRESS		PHONE NUMBER
CONTACT PERSON		PHONE NUMBER	CLIENT AWARE OF REFERRAL? ☐ YES ☐ NO
MI CARD PRESENT ☐ YES ☐ NO	DATE VRB CASE CLOSED		CASE CLOSURE STATUS
VCR NO DATE	RT NO. DATE		OTHER DATE
MEDICARE NO (NUMBER AND SUFFIX)	MEDICAID NO (PREFIX AND NUMBER)		H/C CLINIC & NO
VA NO	SOCIAL SECURITY NO.		SSDI
SSI	WAGE EARNER NAME		SOCIAL SECURITY NO

SECTION II REFERRAL INFORMATION

VISUAL PROBLEM

____

____

VISUAL ACUITY	VISUAL FIELDS	DATE OF ONSET

FUNCTIONAL LIMITATIONS

____

____

EYE SPECIALIST	DATE LAST SEEN
ADDRESS	PHONE NUMBER

OTHER HEALTH PROBLEMS

____

____

____

______________________________ DATE OF ONSET

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FUNCTIONAL LIMITATIONS

PHYSICIAN

DATE LAST SEEN

ADDRESS

PHONE NUMBER

SERVICES REQUESTED

- ☐ EYE CARE
- ☐ OTHER HEALTH CARE
- ☐ COMMUNICATIONS
- ☐ MOBILITY
- ☐ OTHER (SPECIFY) ▶
- ☐ PERSONAL ADJUSTMENT
- ☐ VOCATIONAL ADJUSTMENT
- ☐ VOCATIONAL TRAINING
- ☐ VOCATIONAL EVALUATION
- ☐ JOB PLACEMENT
- ☐ HOMEMAKER
- ☐ INDEPENDENT LIVING

RECEIVING SERVICES FROM ANOTHER AGENCY? ☐ YES ☐ NO (IF YES, COMPLETE BELOW)

AGENCY NAME

ADDRESS

PHONE NUMBER

TYPE OF SERVICES

DIRECTIONS TO HOME

COMMENTS

ACTIONS NEEDED

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SECTION III INITIAL INTERVIEW

STAFF MEMBER	DATE	LOCATION

PARTICIPANTS
☐ CLIENT ☐ SPOUSE ☐ OTHERS (SPECIFY) ▶

LIVING QUARTERS
☐ OWNS HOME ☐ RENTED QUARTERS ☐ HOUSE ☐ APARTMENT

MEMBERS OF HOUSEHOLD

NAME	D.O.B.	RELATIONSHIP	HIGHEST EDUCATION	PRESENT EMPLOYMENT
1.				
2.				
3.				
4.				
5				
6.				
7.				
8.				

COMMENTS

FINANCIAL INFORMATION

SOURCE		AMOUNT
CLIENT EARNINGS (WEEK PRIOR TO REFERRAL)		
TOTAL FAMILY INCOME (MONTH PRIOR TO REFERRAL)		
TOTAL FAMILY P.A. (CURRENT)	TYPE	
CLIENT P.A. (CURRENT)	TYPE	
LENGTH OF TIME CLIENT ON P.A.		

CURRENT INCOME

TYPE	CLIENT	SPOUSE	CHILDREN	PARENTS
SOCIAL SECURITY DISABILITY				
SUPPLEMENTAL SECURITY (SSI)				
AFDC				
GENERAL RELIEF (GR)				
SALARY/WAGES				
VA				
GRANT/ANNUITY TYPE				
INVESTMENT INCOME				
OTHER (TYPE)				

CLIENT'S PRIMARY SOURCE OF SUPPORT ▶

COMMENTS AND ACTIONS NEEDED

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SECTION IV DIAGNOSTIC INFORMATION

A. MEDICAL

VISUAL PROBLEM, ACUITY, FIELDS ______________________________

DATE OF ONSET ______________ FUNCTIONAL LIMITATIONS ______________

OTHER HEALTH PROBLEMS ______________________________

DATE OF ONSET ______________ FUNCTIONAL LIMITATIONS ______________

COMMENTS ______________________________

B. PERSONAL/VOCATIONAL ADJUSTMENT
DAILY ACTIVITIES (MEETS NEEDS OF SELF AND DEPENDENT OTHERS)

	ADEQUATE FOR NEEDS		HAS HAD TRAINING		WANTS TRAINING	
	YES	NO	YES	NO	YES	NO
READING: RP LP B,						
WRITING: S T B,						
EATING TECHNIQUES						
GROOMING TECHNIQUES						
DIAL TELEPHONE						
MONEY IDENTIFICATION						
CLOTHING IDENTIFICATION						
MEAL PREPARATION						
LAUNDRY—WASH IRON						
HOUSECLEANING						
MARKETING						
CHILD CARE						
SEWING — HAND MACHINE						
TRAVEL - METHOD						
INDEPENDENT/NO AIDS						
SIGHTED GUIDE						
LONG CANE						
DOG GUIDE						

COMMENTS ______________________________

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C. EDUCATIONAL HISTORY — ACADEMIC

INSTITUTION	DATE ATTENDED TO
ADDRESS	GRADE COMPLETED 1 2 3 4 5 6 7 8
MAJOR MINOR AREAS	SECONDARY 1 2 3 4 GED
DIPLOMA DEGREE	COLLEGE 1 2 3 4 5 6 6+
VOC COURSES (H S)	SECONDARY CLASS RANK OR GPA
FAVORITE SUBJECTS (H S)	SP ED CLASSES ☐ YES ☐ NO TYPE ▶

D. VOCATIONAL TRAINING — BUSINESS, TRADE, TECHNICAL

INSTITUTION	DATES ATTENDED TO
ADDRESS	COMPLETED ☐ YES ☐ NO
COURSE OF STUDY	REASON FOR LEAVING
JOB SKILLS	CERTIFICATE ☐ YES ☐ NO
INSTITUTION	DATES ATTENDED TO
ADDRESS	COMPLETED ☐ YES ☐ NO
COURSE OF STUDY	REASON FOR LEAVING
JOB SKILLS	CERTIFICATE ☐ YES ☐ NO

E. PERSONAL/VOCATIONAL ADJUSTMENT—REHABILITATION FACILITY OR AGENCY ☐ YES ☐ NO

AGENCY	DATES ATTENDED TO
ADDRESS	COMPLETED ☐ YES ☐ NO
AREAS OF TRAINING	REASON FOR LEAVING
AGENCY	DATES ATTENDED TO
ADDRESS	COMPLETED ☐ YES ☐ NO
AREAS OF TRAINING	REASON FOR LEAVING

F. COMMUNICATION AIDS — VOCATIONAL TRAINING AND JOB PLACEMENT

	PROFICIENT IN USE		AVAILABLE FOR USE	
	YES	NO	YES	NO
TYPEWRITER				
SLATE/STYLUS				
BRAILLER				
CASSETTE RECORDER				
ABACUS				
OTHER (SPECIFY)				

COMMENTS

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G. EMPLOYMENT HISTORY (RECORD LAST EMPLOYMENT FIRST)

☐ NO EMPLOYMENT ☐ HOMEMAKER ☐ PAID EMPLOYMENT (SEE BELOW)

EMPLOYER	EMPLOYED TO
ADDRESS	SALARY AT TERMINATION
REASON FOR LEAVING	
JOB DUTIES	
OCCUPATIONAL SKILLS	

EMPLOYER	EMPLOYED TO
ADDRESS	SALARY AT TERMINATION
REASON FOR LEAVING	
JOB DUTIES	
OCCUPATIONAL SKILLS	

ADDITIONAL EMPLOYMENT HISTORY SHOULD BE REPORTED ON ATTACHED PAGE

COMMENTS

H. ADJUSTMENT TO BLINDNESS

ATTITUDES REGARDING VISUAL LOSS

RELATIONSHIPS WITH OTHERS

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