Center for the Visually Impaired, Inc.
Application for Services

1187 Dunn Avenue, Daytona Beach, FL 32114
*Phone: 386-253-8879 **Toll-free: 800-227-1284**Fax: 386-253-9178*

BLIND BABIES PROGRAM

Personal Information **Today's Date: _____**
Last Name (Baby): _____ First Name: _____
Middle Initial:_____ Preferred Name:_____
Gender:_____ DOB: _____
Parent/guardian Last Name: _____ First Name: _____

Name of Apartment, Condo or Assisted Living Complex (if applicable):_____
Telephone number (of complex) :(___)_____
Home Address: _____
City: _____
County: _____
State:_____ Zip Code:_____
Primary Phone: (___)_____ ☐Voice ☐TDD
Secondary Phone: (___)_____ ☐Voice ☐TDD
E-Mail Address: _____
Directions to Home: _____

Emergency Contact:
Name: _____
Phone Number: _____
Address: _____
Relationship: _____

Characteristics, Race/Ethnic Checkbox list:
☐ **American Indian or Alaskan Native**
☐ **Asian** ☐ **Black or African American**
☐ **Hispanic or Latino** ☐ **Caucasian or White**
☐ **Native Hawaiian or Other Pacific Islander**

☐ Not Available

English Speaking Ability: _____
English Reading Ability: _____
Primary Language: _____

Preferred Correspondence Format: ☐ Audio Tape ☐ Braille
☐ Electronic Media ☐ Large Print ☐ Regular Print

Living Arrangement (private residence, assisted living, etc.):

_____

Resides With (Mother, Father, Grandparents, other etc.):

_____

Medical Insurance Information:

☐ Medicaid
☐ Medicare
☐ Private Insurance through other means
☐ Private Insurance through own employment
☐ Other: _____
☐ None

Disability Documentation:
Visual Impairment Due To (ROP, glaucoma, etc):

_____

_____

Are there any additional medical conditions (such as, shortness of breath, seizure disorder, etc.)? Please explain:

_____

_____

Training Preference: (Home, Center, etc.)

_____

Eye Physician: _____

Location of Eye Doctor: _____

Phone number: (___) _____

Date last seen: _____

Referral Source: (Check one)
☐ **Eye Doctor** ☐ **Friend / Relative** ☐ **DBS** ☐ **CVI Presentation**

☐ **Other:** _____

Do you use any of the following mobility aids?
☐ **Cane** ☐ **Walker** ☐ **Wheelchair**

Special Needs: Personal Assistant (do you need assistance with personal needs, i.e. restroom)? Explain: _____

_____

_____ _____

Parent/Guardian Signature **Date**

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Vision Consent for Release of Information

ATTENTION:

FROM: Alauna Williams, Client Services at CVI

EYE DOCTOR'S NAME:

DATE:

EYE DOCTOR'S PHONE NUMBER:

PATIENT'S NAME:

EYE DOCTOR'S FAX NUMBER:

PATIENT'S DATE OF BIRTH:

I give the Center for the Visually Impaired and the Florida State Division of Blind Services permission to request information relevant to my rehabilitation program. This information will not be released to another individual or agency without my written consent as permitted by law.

Signature: _____ Date: _____

PHYSICIAN

PLEASE USE THE INCLUDED FORM