

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

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