

Department Education - Division of Blind Services  
**APPLICATION FOR ECONOMIC NEED**



CLIENT NAME \_\_\_\_\_ SSN \_\_\_\_\_

The information on this form is used to determine if you qualify for services that are based on economic need.

Client's Income From All Sources	Monthly Gross Income	Source of Income (e.g. Employment, SSI, VA)

Total Number of Persons in Household \_\_\_\_\_ Total Monthly Income of Household \$ \_\_\_\_\_

Family Group(Sharing Income and Expenses)	Age	Relationship	Monthly Gross Income	Source of Income (e.g. Employment, SSI, VA)

<b>CLIENT'S HEALTH INSURANCE</b>	Insurance Carrier _____ Policy # _____
	Medicare ___ Policy # _____ Medicaid ___ Policy # _____
	VA _____ Other _____

<b>RESOURCES AVAILABLE</b>	Liquid Assets (Cash, Stocks, Bank Accounts)	\$ _____
	Real Estate (Income earning - Not client's home)	\$ _____
	Other Resources	\$ _____
	<b>Total</b>	\$ _____

I certify this information is complete and accurate to the best of knowledge. I agree to use private insurance, Medicare, and/or Medicaid first in paying for medical treatment if it is needed.

\_\_\_\_\_  
 Client's Signature/Date

\_\_\_\_\_  
 Rehabilitation Specialist Signature/Date

<b>FOR OFFICIAL USE ONLY</b>					
Eligible ___ Not Eligible ___ Exception Recommended ___ (See Back)					
Updates (Initial & Date)					

DIVISION OF BLIND SERVICES  
REFERRAL AND APPLICATION FOR SERVICES  
Updated and revised 10/09

DBS Use: VR - IL -CF\_\_ \_\_\_\_\_  
Date Received: \_\_\_\_\_  
  
(Date Stamp)

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Social Security Number \_\_\_\_\_

Florida Department of Education Division of Blind Services  
Social Security Number Collection Policy

In compliance with Section 119.071(5), Florida Statutes, this statement serves to notify you of the purpose for the collection and usage of your social security number by the Florida Department of Education, Division of Blind Services (“Division”).

Collection of social security numbers is imperative for the performance of the Division’s duty to maximize employment opportunities for individuals who are blind; to aid such individuals in finding employment; and to increase their independence and self-sufficiency.

Date of Birth \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Other Phone # \_\_\_\_\_

Street Address or PO Box \_\_\_\_\_

If applicable list apartment # and name or Lot number and name of park \_\_\_\_\_

Directions to your home \_\_\_\_\_

Email address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ Zip \_\_\_\_\_

Race \_\_\_\_\_ Registered Voter Yes \_\_\_ No \_\_\_ Primary Language \_\_\_\_\_

Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Highest Level of Education \_\_\_\_\_

School last attended and date \_\_\_\_\_

Are you a Veteran Yes \_\_\_ No \_\_\_ Referred by \_\_\_\_\_

Emergency Contact not living with you (Name, Address, & Relationship) \_\_\_\_\_

US Citizen Yes \_\_\_ No \_\_\_ (If no list status) \_\_\_\_\_

Are you employed? \_\_\_\_\_ If yes, full-time or part-time \_\_\_\_\_

If yes, what is your position title? \_\_\_\_\_

Eye Condition \_\_\_\_\_

Eye Physician \_\_\_\_\_

Date Last Seen \_\_\_\_\_

Have you ever received services from this Agency? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, when? \_\_\_\_\_

I understand that I am applying for services from the Division of Blind Services and that all eligibility is determined without regard to race, color, religion, sex, national origin, age marital status, or handicap.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

I would like information in: \_\_\_\_\_ regular print \_\_\_\_\_ large print \_\_\_\_\_ on tape \_\_\_\_\_ braille

I am interested in the following service(s):

\_\_\_ Independent Living Training    \_\_\_ Counseling    \_\_\_ Job Training    \_\_\_ Eye Medical Services

\_\_\_ Job Placement    \_\_\_ Talking Books    \_\_\_ Assistance to Maintain Job

\_\_\_ Other \_\_\_\_\_

Local Blind Service Office Addresses Located on Back

DIVISION OF BLIND SERVICES DISTRICT OFFICES

Division of Blind Services  
14 W. Jordan Street  
Suite 1M  
Pensacola, FL 32501  
850-595-5282

Division of Blind Services  
(Satellite office of Pensacola)  
234 Forest Park Circle  
Panama City, FL 32405  
Tel: 850/872-4181

Division of Blind Services  
1320 Executive Center Drive  
Atkins Bldg. 201  
Tallahassee, FL 32399  
Tel: 850/245-0307 or 1-800-672-7038

Division of Blind Services  
1809 Art Museum Drive, Suite 201  
Jacksonville, FL 32207  
Tel: 904/348-2730 or 1-800-226-6356

Division of Blind Services  
417 S.W. 8th Street  
Gainesville, FL 32601  
Tel: 352/955-2075 OR 1-800-443-0908

Division of Blind Services  
1185 Dunn Avenue  
Daytona Beach, FL 32114  
Tel: 386/254-3800 or 1-800-329-3801

Division of Blind Services  
400 W. Robinson Street, Suite 102  
Orlando, FL 32801-1784  
Tel: 407/245-0700

Division of Blind Services  
415 S. Armenia Avenue  
Tampa, FL 33609-3313  
Tel: 813/871-7190 or 1-800-757-7190

Division of Blind Services  
(Satellite office of Tampa)  
402 S. Kentucky Avenue, Room 310  
Lakeland, FL 33801  
Tel: 863/499-2385

Division of Blind Services  
(Satellite office of Tampa)  
3637 4th Street North, Suite 310  
St. Petersburg, FL 33704  
Tel: 727/893-2341 or 1-800-909-9632

Division of Blind Services  
(Satellite office of Ft. Myers)  
5117 26th Street West, Suite A  
Bradenton, FL 34207  
Tel: 941/751-7670 or 1-800-500-6412

Division of Blind Services  
2830 Winkler Avenue  
P.O. Box 7348  
Ft. Myers, FL 33911-7348  
Tel: 239/278-7130 or 1-800-219-0180

Division of Blind Services  
2000 Palm Beach Lakes Blvd., Suite 300  
West Palm Beach, FL 33401  
Tel: 561/681-2548 or 1-866-225-0794

Division of Blind Services  
2200 W. Commercial Blvd., Suite 101  
Ft. Lauderdale, FL 33309  
Tel: 954/497-3360

Division of Blind Services  
401 N.W. 2nd Avenue, Room S-712  
Miami, FL 33128  
Tel: 305/377-5339 or 1-888-529-1830

## Appendix H

### **RIGHTS PROVIDED UNDER THE ADULT PROGRAM (AP)** **AND** **CHILDREN AND FAMILIES PROGRAM (CFP)** **Division of Blind Services**

Applicants or clients of the AP and the CFP have similar rights offered through the Division of Blind Services (DBS). The Individuals with Disabilities Education Act (IDEA) provides additional rights to CFP individuals.

The rights of both applicants and clients of these two programs include:

- The right to apply for services;
- The right to an eligibility determination within 60 days of application submission, 30 for children;
- The right to know the basis of eligibility or ineligibility determination and written notice prior to closure of the file;
- The right to review any decisions concerning denial or provision of services or change in services;
- The right to confidentiality of records and reports (release of this information to any person, agency or organization will be done only with the assurance that the information will be used to further rehabilitation efforts);
- The right to be notified whenever records or reports are legally released without the individual's prior knowledge;
- The right to participate in the planning of services;
- The right to advance notice of certain changes in the Service Plan which is called the Individualized Plan of Service (IPS);

- The right to freedom from discrimination based on sex, race, color, religion, origin, age, marital status, political affiliation, disability, or veteran status;
- The right to an explanation of and to be informed about the DBS review process:
  - A. When they initially apply for services;
  - B. If they are found ineligible for services; and
  - C. When services are being terminated, suspended, or reduced.

Applicants or eligible individuals have a right to request a review of any decision made by DBS regarding their program. At any time an applicant/client is entitled to request one of the three review processes described below. A district applicant/client may request such a review through informal review process, (district review conducted by a District Supervisor or District Administrator, or an administrative review conducted by the Bureau Chief of Client Services,) or formal review (Fair Hearing) procedures outlined below.

### **INFORMAL REVIEW PROCESS**

DBS procedures for conducting informal reviews are initiated by an applicant or eligible client requesting a review, with regard to a decision made by a rehabilitation specialist or supervisor concerning the provision or denial of services.

- a. Review is conducted by the specialist's direct supervisor or District Administrator at the verbal or written request of an applicant or eligible individual or, as appropriate, his/her representative.
- b. Administrative Review: If an individual is dissatisfied with the results of a district review or chooses to bypass a district review, he/she may make a written request for an administrative review to be conducted by the Client Advocate or designee. The Client Advocate shall act on behalf of the client and may take a position adverse to that of Client Services.

The Client Advocate shall contact the District Office Involved to ascertain

the facts and law that the District Office relies upon. If the Client Advocate determines the action of the District Office to be incorrect, he shall recommend the District Office take corrective action. If the District Office disagrees with the recommendation of the Client Advocate, the issue shall be brought before the Division Director for resolution. If the Client Advocate concurs with the action of the District Office, he shall so inform the client in writing.

Both reviews must be conducted and a written decision provided within a time frame agreed upon by both parties, but at least within 45 days of the request to allow for a formal review if desired and requested by the individual. The informal review process will not delay a formal hearing if so desired by the individual unless the individual or, as appropriate his/her representative, agrees upon an extended time frame. A written decision resulting from either a district/review or administrative review must be included in the individual's record of services.

## **FORMAL REVIEW PROCESS**

- a. **Impartial Due Process Hearing Procedures:** An applicant or eligible individual may request a formal review/Fair Hearing of a decision concerning the furnishing or denial of services through the process of a Fair Hearing. The Fair Hearings are conducted by an impartial hearing officer from the Florida Department of Administrative Hearings (DOAH), within 45 days of a written request by the individual, unless informal resolution is achieved prior to the 45th day or the parties agree to a specific extension of time. The individual must submit such a request within 30 days of the decision regarding service provision to the DBS Director. DBS does not suspend, reduce, or terminate services being provided under an evaluation, assessment, or individualize plan of services (IPS). Such services will be provided pending a final resolution through either informal or an impartial due process hearing unless there is evidence that such services have been obtained through misrepresentation, fraud, collusion, or criminal conduct on the part of the individual.

The individual, or individual's representative, must be afforded the opportunity to provide additional evidence, information, and witnesses, as well as the opportunity to examine all witnesses and other relevant information and evidence. The individual may elect to be represented by counsel or other appropriate advocate.

The DOAH impartial hearing officer will make a decision based on the policies and procedures of the Division. A written report of the findings will be provided to the individual or, if appropriate, his/her representative, within 30 days of completion of the hearing.

Except for time limitations established in law, reasonable time extensions may be provided for good cause shown at the request of either or both parties.

A decision made by the Secretary is final unless the party aggrieved by such decision brings a civil action in any State court of competent jurisdiction or in a district court of the United States of competent jurisdiction without regard to the amount of controversy.

## **RIGHTS UNDER THE IDEA LEGISLATION**

Students who are blind or visually impaired and who have an Individualized Education Program (IEP) prepared under the local school system are provided rights under the Individuals with Disabilities Education Act (IDEA). Rehabilitation specialists will inform parents of these rights and assist parents in receiving services. The advocacy center can provide information regarding rights of school aged students.



## **Independence for the Blind of West Florida**



### **IBWEST CONSUMER RIGHTS AND RESPONSIBILITIES**

IBWEST is a not-for-profit corporation dedicated to assisting persons who are visually impaired in achieving the maximum level of independence in their lives. Services contained within the various Programs are provided both at our training facility in a group or one on one setting, and on an outreach basis. Programs include training in communications, assistive technology, orientation and mobility, techniques of daily living (home and personal management), leisure activities, advocacy, and individual and family adjustment services. Services are provided without charge and without regard to individual or family income level, race, creed, age, disability or national origin.

#### **COUNSELOR RESPONSIBILITY**

Upon referral for services you will be assigned an Instructor. It is your Instructor's responsibility to help you plan and implement a program that will insure that you receive the best services possible. Your Instructor will work with you in making important decisions concerning your program your full participation; your Instructor will assist you in deciding which services are most appropriate to help you achieve your desired level of independence. It is also reasonable to expect from your Instructor courteous and respectful treatment, honest answers regarding eligibility for and provision of services, prompt service delivery, frequent contacts, periodic reviews of your written plan, and cooperation in any appeal you wish to make.

#### **CONSUMER RIGHTS**

As a client of IBWEST, you have the right to a thorough evaluation to determine your eligibility for services and, if determined ineligible, the right to know the reason. You also have the right to participate in planning the services you will receive as well as advance notice and consultation regarding any changes in your written plan. You also have the right to review your case records and to be assured of the confidentiality of your records and reports. You also, have the right to receive services in a timely manner and free from discrimination based on sex, race, color, creed, origin age or disability. You also have the right to appeal any decision concerning the denial of services, or changes in the service you will receive.



## **CONSUMER RESPONSIBILITY**

As a client of IBWEST you will be expected to cooperate with your Instructor in all phases of the program. You are encouraged to participate in the planning of your overall plan and to speak up if you disagree with your Instructor. You are expected to actively participate in the execution of your overall program to work toward the achievement of your goals and objectives, and to discuss with your Instructor any desired changes in your overall plan. It is also your responsibility to initiate the appeal of any decision or service with which you disagree.

## **RIGHT TO APPEAL**

You have the right to appeal any decisions, actions, or changes with which you disagree, such as a denial of services, changes in planned services, case inaction or lack of prompt service, case closure, or other actions that affect your ability to participate in services that will enable you to reach your goals and objectives. If you wish to request an appeal, you must file a request for an administrative review with the Executive Director. This request should be in writing or in some other format accessible to you such as Braille or tape. If, after review by the Executive Director, your grievance has not been resolved to your satisfaction, you may request a formal hearing of your complaint before the Board of Directors. You will then be notified in writing on the Board's decision. Any further appeals must be taken to the court system.

## **AGENCY RIGHT TO REFUSE OR TERMINATE SERVICES**

IBWEST reserves the right to refuse, suspend, or terminate services to any individual if there is sufficient reason to suspect that illegal activities are taking place on the premises or if the situation poses a real or perceived threat of bodily harm. A reasonable effort will be made to arrange for an alternative meeting site before services are terminated. Services may also be discontinued if, after a reasonable amount of time has been allowed, a client fails to make sufficient effort on progress toward goal achievement. Closure will also occur when all services have been completed and no additional services have been requested. The client must be fully consulted before closure is executed.

I have been informed of my rights and responsibilities as a client of IBWEST. I have been provided a copy of those rights and responsibilities. That copy has been provided to me in the format I requested.

\_\_\_ Client received Large Print Copy

---

Client Signature

---

Date



## PHOTO RELEASE

I \_\_\_\_\_ do hereby grant full permission to  
**Independence for the Blind of West Florida, Inc. and the  
Florida Division of Blind Services**, to use videos or photographs  
of myself for future promotional materials.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Parent/Guardian Signature if under 18

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian





## Independence for the Blind of West Florida

### AUTHORIZATION FOR RELEASE OF INFORMATION

I \_\_\_\_\_ hereby authorize the release of eye medical records to Independence for the Blind of West Florida, Inc. Further, I understand that this information is now, or will be, needed to establish my eligibility for services. This information may be shared with other agencies that may cooperate with Independence for the Blind in providing rehabilitation services to me.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

DOB  
SSN#

**\*Please include a copy of the narrative report. Thank you.**

**\* Only the most recent eye report is needed.**

**Independence For The Blind  
3107 North Davis Highway  
Pensacola, FL 32503**