STATE OF MAINE – DEPARTMENT OF LABOR

BUREAU OF REHABILITATION SERVICES

DIVISION FOR THE BLIND AND VISUALLY IMPAIRED

150 State House Station, Augusta, ME 04333-0150

Governor - Janet T Mills **Commissioner - Laura Fortman**

Application for Blind Independent Living Services

This application is for Individuals who have a visual impairment or blindness and are not seeking employment. All fields are required.

PERSONAL INFORMATION

Social Security Number (SSN):

_____

Full Name:

_____

What is your gender? Please mark below:

- Female ☐
- Male ☐
- Prefer not to say/Do not want to identify ☐

Date of Birth (DOB):

_____

Street Address/PO Box:

_____

City/Town, State, Zip Code:

_____

Mailing Street Address/PO Box (if different):

_____

Mailing City/Town, State, Zip Code (if different):

_____

Primary Telephone Number:

_____

Secondary Telephone Number/Cell Phone Number:

_____

Email Address:

_____

DEMOGRAPHIC INFORMATION

What is your race? Please mark below:

- American Indian or Alaska Native ☐
- Asian ☐
- Black or African American ☐
- Native Hawaiian or Other Pacific Islander ☐
- White ☐
- Do not want to self-identify ☐
- Two or more races ☐

If applicable, what is your Ethnicity? Please mark below:

- Hispanic or Latino ☐
- N/A ☐

Primary/Preferred Language:

_____

What is your preferred method of correspondence? Please mark below:

- Phone ☐
- Large Print (18 pt) ☐
- Standard Print (14 pt) ☐
- Email ☐
- Braille ☐

ALTERNATE CONTACT INFORMATION

Do you have a Legal Guardian? List Yes or No:

_____

If you have a Legal Guardian, please write their name, address, phone number and email address:

Primary Emergency Contact

Emergency Contact's Full Name:

_____

Emergency Contact's Street Address:

_____

Emergency Contact's City/Town, State, Zip Code:

_____

Emergency Contact's Phone Number:

_____

Emergency Contact's Email Address:

_____

Secondary Emergency Contact (if applicable)

Emergency Contact's Full Name:

_____

Emergency Contact's Street Address:

_____

Emergency Contact's City/Town, State, Zip Code:

_____

Emergency Contact's Phone Number:

_____

Emergency Contact's Email Address:

_____

BASIC INFORMATION

What is your living arrangement? Please mark below:

- Private Residence (House or Apartment) ☐
- Senior Independent Living Facility ☐
- Nursing Home/Long Term Care Facility ☐
- Homeless ☐

Are you registered to vote? Please list Yes or No:

_____

If you are NOT registered to vote, do you want a voter registration form? Please list Yes or No: _____

What is your Marital Status? Please mark below:

- Married ☐
- Divorced ☐
- Widowed ☐
- Separated ☐
- Single ☐

Are you a U.S. Citizen? Please list Yes or No:

_____

What is your primary source of support? Please mark below:

- Family/Friends ☐
- Personal Income/Wages ☐
- Public Support (SSI, SSDI, TANF, etc) ☐
- Personal Income: Interest, Dividends, Rent ☐
- Other ☐

_____

Do you receive any of the following benefits or income? Please mark below:

- SSI-Aged ☐
- SSI-Disabled ☐
- SSDI-Disabled ☐
- SSDI-Other ☐
- VA ☐
- TANF ☐
- General Assistance ☐
- Worker's Compensation ☐
- Unemployment ☐
- Other Disability ☐

What medical insurance do you have? Please mark below:

- MaineCare ☐
- Medicare ☐
- Private through other means ☐
- Private through own work ☐
- Public insurance from other sources ☐
- None ☐
- State/Federal Affordable Care Act Exchange ☐

Are you a veteran? Please list Yes or No:

_____

Have you ever been convicted of any violation of law by any court? Please list Yes or No:

_____

If you answered Yes to the above question, please describe:

What is the cause of your visual impairment? Please mark below:

- Macular Degeneration ☐
- Diabetic Retinopathy ☐
- Glaucoma ☐
- Cataracts ☐
- Other ☐ _____

Do you have any other impairments? Please mark below:

- Deaf/Hard of Hearing/Late Deafened ☐
- Mobility Impairment ☐
- Communication Impairment ☐
- Cognitive or Intellectual Impairment ☐
- Mental Health Impairment ☐
- Other ☐ _____
- None ☐

PRIMARY DOCTOR (PCP) INFORMATION

PCP Name:

_____

PCP Street Address:

_____

PCP City/Town, State, Zip Code:

_____

PCP Phone Number:

_____

Date Last Seen:

_____

PRIMARY EYE DOCTOR INFORMATION

Primary Eye Doctor Name:

_____

Primary Eye Doctor Street Address:

_____

Primary Eye Doctor City/Town, State, Zip Code:

_____

Primary Eye Doctor Phone Number:

_____

Date Last Seen:

_____

OTHER DOCTOR/HOSPITAL/CLINIC INFORMATION

Name:

_____

Street Address:

_____

City/Town, State, Zip Code:

_____

Phone Number:

_____

Date Last Seen:

_____

OTHER AGENCIES AND SERVICES INVOLVED AT APPLICATION INFORMATION

Please list all names, addresses, and phone numbers:

SIGNATURE

By signing below, you are applying for services from The Maine Division for the Blind and Visually Impaired Independent Living Program.

Signature:

_____

Name (Please Print):

_____

Date:

_____

Legal Guardian Signature (if applicable):

_____

Legal Guardian Name (Please Print):

_____

Date:

_____

Please return this form by fax or email:

Fax 207-879-7553

Email: applications.dbvi@maine.gov

Questions? 866-DBVI-4-ME (866-328-4463)

TTY – Maine Relay 711

The Maine Department of Labor provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. Programs are provided as a proud partner of the American Job Center network.