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|  | MISSOURI DEPARTMENT OF SOCIAL SERVICES  FAMILY SUPPORT DIVISION  **OLDER BLIND GRANT DATA SHEET – OBS 1** | | | | | | | | |
| **NAME** (LAST, FIRST, MI) | | | | | | **CASE NUMBER** | | | |
| **ADDRESS** (STREET OR RR) | | | | | | | | | |
| **CITY** | | | | **STATE** | | **ZIP CODE** | | | **COUNTY AND NO.** |
| **TELEPHONE** | | | **SOCIAL SECURITY NUMBER** | | | | **DATE OF BIRTH** (MONTH, DAY, YEAR) | | |
| **REFERRAL DATE** | | **APPLIC. DATE** | **CASELOAD NUMBER** | | **PREVIOUS OBS CASE** | | | IF YES, DATE OF CLOSURE | |
| **DATE OF ELIGIBILITY** | | | | | **GENDER**  (1) FEMALE  (2) MALE | | | | |
| **RACE/ETHNICITY**  (1) HISPANIC/ LATINO OF ANY RACE OR HISPANIC/LATINO ONLY  (2) AMERICAN INDIAN OR ALASKA NATIVE  (3) ASIAN  (4) BLACK OR AFRICAN AMERICAN  (5) NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER  (6) WHITE  (7) TWO OR MORE RACES  (8) RACE AND ETHNICITY UNKNOWN ( Only if consumer refuses to identify) | | | | | | | | | |
| **DEGREE OF VISUAL IMPAIRMENT**  (1) TOTALLY BLIND (LP ONLY OR NLP)  (2) LEGALLY BLIND (EXCLUDING TOTAL BLINDNESS). REPORTED/SNELLEN ACUITY:  (3) SEVERE VISUAL IMPAIRMENT, PROGRESSIVE CONDITION – 20/70 OR WORSE CORRECTED BILATERAL  ACUITY. REPORTED/SNELLEN ACUITY: | | | | | | | | | |
| **MAJOR CAUSE OF VISUAL IMPAIRMENTS ( CHECK ONLY ONE MAJOR VISUAL IMPAIRMENT )**  (1) MACULAR DEGENERATION  (2) DIABETIC RETINOPATHY  (3) GLAUCOMA  (4) CATARACTS  (5) OTHER | | | | | | | | | |

MO 886-4003 (10-08) PAGE 1 OBS-1

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| **OTHER AGE RELATED IMPAIRMENTS**  (CHECK ALL THAT APPLY)  (1) HEARING IMPAIRMENT  (2) DIABETES  (3) CARDIOVASCULAR DISEASE AND STROKES  (4) CANCER  (5) BONE, MUSCLE, SKIN, JOINT, AND MOVEMENT DISORDER  (6) ALZHEIMER'S DISEASE/ COGNITIVE IMPAIRMENT  (7) DEPRESSION/MOOD DISORDERS    (8) OTHER MAJOR GERIATRIC CONCERNS |
| **TYPES OF LIVING ARRANGEMENTS**  (1) LIVES ALONE  (2) LIVES WITH OTHERS (FAMILY, SPOUSE, CARETAKER, ETC) |
| **TYPES OF RESIDENCE**    (1) PRIVATE RESIDENCE (HOUSE OR APARTMENT)  (2) SENIOR LIVING/RETIREMENT COMMUNITY  (3) ASSISTED LIVING FACILITY  (4) NURSING HOME/LONGTERM CARE FACILITY  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **SOURCE OF REFERRAL**  (1) EYE CARE PROVIDER (OPHTHALMOLOGIST, OPTOMETRIST)  (2) PHYSICIAN/MEDICAL PROVIDER  (3) STATE VR AGENCY  (4) GOVERNMENT OR SOCIAL SERVICE AGENCY  (5) SENIOR PROGRAM  (6) FAITH-BASED ORGANIZATION  (7) INDEPENDENT LIVING CENTER  (8) FAMILY MEMBER OR FRIEND  (9) SELF-REFERRAL  (10) VETERANS ADMINISTRATION  (11) OTHER  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **DO YOU FEEL, AFTER DISCUSSION OF THE SERVICES OFFERED BY REHABILITATION SERVICES FOR THE BLIND, THAT YOUR HEALTH WILL ALLOW YOU TO BE MORE INDEPENDENT?**  YES  NO |

MO 886-4003 (10-08) PAGE 2 OBS-1

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| Services administered by Rehabilitation Services for the Blind, Missouri Family Support Division are in compliance with the Civil Rights Act of 1964 and/or section 504 of the Rehabilitation Act of 1973, as amended. An application presumed eligible for Older Blind Services from the State when evidence exists which establishes that the applicant has a significant disability and meets the eligibility criteria for Older Blind Services. Discrimination against any person on the basis of race, national origin, religion, political preferences, or disabling condition is prohibited. All information given by me to a representative of Rehabilitation Services 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 have right of appeal if my application is denied or if it is not acted upon promptly. I have the right to an administrative review. I may exercise this option by putting my request in writing to the District Supervisor of the local Rehabilitation Services for the Blind office,       **.** In addition, Missouri Protection and Advocacy Services operates a **Client Assistance Program** which may be of interest and help to me. The Client Assistance Program provides several services including assistance in pursuing legal, administrative, or other solutions to protect my 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.  The **Client Assistance Program** is available by writing or telephoning:  Missouri Protection and Advocacy Services  925 South Country Club Drive  Jefferson City, MO 65109  **Telephone: 1-800-392-8667**  I can obtain further information on my rights to appeal by contacting the RSB representative whose name, address, and telephone number are shown below.  **Missouri Rehabilitation Services for the Blind** | | |
| **RSB REPRESENTATIVE** | **TELEPHONE NUMBER** | |
| **APPLICANT SIGNATURE** | | **DATE** |

MO 886-4003 (10-08) OBS-1