DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Public Health
F-22468 (07/2016)

APPLICATION FOR SERVICES WITH THE OFFICE FOR THE BLIND AND VISUALLY IMPAIRED

INSTRUCTIONS: Complete and sign this form. Completion of this form is voluntary. Personally identifiable information collected on this form is confidential and will only be used in determining eligibility for services.

Name – Consumer Last	First	M.I.

Street or P.O. Box	Apartment Number

City	Zip Code	County

Telephone Number (Include Area Code)

Email Address

Birthdate (mm/dd/yyyy)	Sex Male ☐ Female ☐	Date of Onset

Race / Ethnicity	Highest Level of Education

Source of Referral	Marital Status

Alternate Contact Person Section

Name – Alternate Contact	Relationship

Telephone Number

List your type of residence (e.g. House, Apartment, Assisted Living Facility, Nursing Home)

Do you live alone or with others? Live Alone ☐ With Others ☐

Are you a U.S. Veteran? Yes ☐ No ☐

What is your visual impairment?

How does your visual impairment impact your ability to complete daily living tasks / activities?

Name – Eye Doctor **Date of Last Exam**

Please list any other health concerns or conditions.

X SIGNATURE – Consumer / Representative	**Date Signed**