WORLD SERVICES FOR THE BLIND
2811 Fair Park Boulevard • Little Rock, AR 72204
501-664-7100 • 501-664-2743 (Fax)

ADMISSIONS APPLICATION

I. PERSONAL INFORMATION DATA

Date: _____

Name: _____ Telephone: _____

Address (Street/City/State/Zip): _____

Email: _____ Date of Birth: _____

Last 4 Digits of SSN: _____ Insurance Carrier:

Age: _____ Sex: _____ Ethnicity: _____ Height: _____ Weight: _____

Marital Status: Married____ Single____ Widowed____ Divorced____ Separated____

Children? If yes, please include ages: _____

Live With: Spouse____ Parent(s)____ Caretaker____ Live Alone____ Other: _____

Name, address and telephone number of nearest relative (or guardian, if minor): _____

_____

II. DISABILITY DATA

* Visual Acuity: R _____ L _____ Diagnosis _____

*Other Disabilities (including mental health issues): _____

_____

Current Medication: _____

_____

Self Administered? Yes____ No (specify assistance needed) _____

*Note: Please share copies of the most recent medical, ophthalmological and other special medical and psychological reports. **If a special diet is required, please specify (i.e., vegan, religious, diabetic, etc.).**

III. LEGAL ISSUES

Have you ever been convicted, imprisoned, on probation or on parole? (Includes felonies, firearms or explosives violations, misdemeanors and all other offenses) If yes, please provide the date, explanation of the violation, place of occurance, and the name and address of the police department or court involved.

Please Explain: _____

_____

IV. EDUCATION

Education Completed: Grade _____ Year _____ School for the Blind _____ Public _____

College: Year _____ Degree? _____ Major _____ Date _____

Name and Location of College: _____

*Note: Please share copies of your most recent college transcripts, if applicable.

Do You: (check all that apply) Travel with sighted guide ____ Have mobility Impairments ____ If yes, do you Use a mobility cane ____ Use a standard wheelchair ____ Use oversized wheelchair ____ Use a scooter ____ Use a guide dog ____ Other: (please explain) _____

Do You: (check all that apply) Use JAWS ____ Use ZoomText ____ Use a Braille Display ____ Use a Braille Note Taker ____ Other: (please explain) _____

Braille Skills: Yes ____ No ____ If yes, select skill level: ☐ Braille I ☐ Braille II

V. WORK DATA

Most Recent Job: _____

Dates: _____ Salary: _____

Job Held Longest: _____ Dates: _____

Financial Status: Monthly Income _____

Source of Income: (please specify amount of each) SSDI _____ SSI _____ Other _____

VI. PLANNING DATA

1. Career Training Program: 1. _____ 2. _____

Career Training Program Selection is: Firm _____ Tentative _____ ***OR***

Life Skills only _____

VII. SPECIAL SERVICES DESIRED

In addition to an evaluation and life skills training, what other services are needed while at WSB?

_____

In your opinion, what is the most important service that will assist in meeting your needs?_____

_____

VIII. REHABILITATION COUNSELOR SECTION

During training, who pays for medical services? Client_____ Agency_____ Other_____

During training, who pays for medication? Client_____ Agency_____ Other_____

During training, who provides personal incidental monies? Client_____ Agency_____ Other_____

At the end of training, who pays for transportation home? Client_____ Agency_____ Other_____

PLEASE SEND CERTIFICATION OF ELIGIBILITY WITH MEDICAL & VISION REPORTS

APPLICANT'S SIGNATURE: _____

COUNSELOR'S SIGNATURE: _____

AGENCY: _____

ADDRESS: _____

_____

PHONE:_____ **FAX:** _____

EMAIL: _____

IX. In order that World Services for the Blind may safeguard the welfare of _____
(Applicant's Name)

you are authorized to obtain emergency medical and/or hospital services under your medical consultation without further instructions. I also agree that you may secure and share medical, psychological and other reports with my sponsoring agency.

Signed:_____
(Applicant or Legal Guardian)

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to **World Services for the Blind** (2811 Fair Park Blvd Little Rock, AR phone: 501-664-7100 fax: 501-664-2743)
This authorization for release of information covers the period of healthcare from:

a. □ _____ to _____ (1yr previous to the date of signing)

1. Extent of Authorization
I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

2. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

3. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

5. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient

_____

Date