ASSOCIATED SERVICES
FOR THE BLIND
AND VISUALLY IMPAIRED

919 Walnut Street
Philadelphia, PA 19107

(215) 627-0600
www.asb.org

Dear Potential Client:

Thank you for your interest in Associated Services for the Blind and Visually Impaired. In order to schedule an intake appointment, we would request that you fill out the materials below. Once completed, please send forms to the ASB staff via mail, email or fax.

Necessary client documents to be completed and submitted include:

- Contact Information Form
- ASB Eye Report

If you think you may be qualified to receive financial assistance for specific services, please include **one** of the following **additional** documents below when submitting your client intake application to the ASB staff:

- **1040 federal or state tax return.** It must contain your first and last name, income amount, and tax year.
- **Wages and tax statement** (W-2 and/ or 1099, including 1099 MISC, 1099G, 1099R, 1099SSA, 10990IV, 1099SS, 1099INT). It must contain your first and last name, income amount, year, and employer name (if applicable).
- **Social Security Administration Statements** (Social Security Benefits Letter). It must contain first and last name, benefit amount, and frequency of pay.
- **Unemployment Benefits Letter.** It must contain your first and last name, source/ agency, benefits amount, and duration (start and end date, if applicable).

Client confidentiality is of utmost importance to ASB. To ensure all personal information is sent securely, please complete and send finalized documents to ASB via a secure method including USPS mail, email or fax. **No personal information should be submitted through the ASB website.**

Completed forms can be sent via:

Mail: Associated Services for the Blind, 919 Walnut St, Philadelphia, PA 19107
Email: ASBReferrals@asb.org
Fax: (215) 922–0692

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Contact Information

Name: _____ Today's Date (mm/dd/yyyy): ___/___/___

Date of Birth (mm/dd/yyyy): ___/___/___ New Client ☐ Returning Client ☐

Phone Number: _____ Mobile ☐ Home ☐

Email Address: _____

Mailing Address: _____ City: _____

County: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Emergency Contact Relationship: _____

How did you hear about ASB?

- ☐ Primary Care Physician: _____
- ☐ Eye Specialist: _____
- ☐ Hospital: _____
- ☐ Friend
- ☐ Relative
- ☐ Bureau of Blind and Visual Services
- ☐ Philadelphia Corporation for the Aging
- ☐ Other: _____

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ASB Eye Report

I hereby authorize the Associated Services for the Blind & Visually Impaired to request information concerning the condition of my eyes as it may be essential to the expedient and efficient provision of services.

_____ / / _____

Client Signature | Date of Birth

_____ _ _ _____

Print Client's Name | Client's SSN

This individual is being considered for services whose funding may require that the person is considered visually impaired and eligible for services if he-she has a "visual acuity with the best correction of 20/70 in the better eye, or has a corresponding loss of visual fields, or any progressive sight threatening disease or a significant functional limitation."

Diagnosis & Etiology: _____

Visual Acuity—With Best Correction OD: _____ OS: _____

Visual Field—Angle of widest diameter of field of vision OD: _____ OS: _____

Based on this definition, the visual function of this person examined is:

Visually Impaired ☐ Not Visually Impaired ☐

Prognosis: _____

Comments and Recommendations: _____

_____

Date of Examination: / / Date of Report: / /

_____

Print Doctor's Name | Doctor's Signature

_____

Doctor's Address