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, 1099OIV, 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
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: ____________________________
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
ASB Release of Information

Karla McCaney, President & Chief Executive Officer

To Whom It May Concern:

The client, whose signature appears below, has requested that:

- You provide Associated Services for the Blind and Visually Impaired with the following information specified below, or
- Associated Services for the Blind and Visually Impaired is permitted to send specified information on the client’s behalf as authorized by their signature.

The information will/should be kept confidential unless written permission is obtained from the client. If you have any questions regarding this, please contact Beth Deering, Director of Human Services at 215-627-0600 x3255 or at bdeering@asb.org.

CONSENT FOR RELEASE OF INFORMATION

- I authorize the following (individual/agency)
  ___________________________________________ and the Bureau of Blindness and Visual Services to provide information to Associated Services for the Blind and Visually Impaired.

- I authorize Associated Services for the Blind and Visually Impaired to share information with ___________________________________________ and the Bureau of Blindness and Visual Services.
ASB Release of Information (cont.)

The specific information is permitted to be shared is the following:

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

This consent is valid for one year from the following date indicated below.

Client Name (print):______________________________________________________
Date of Birth:___________________________________________________________
Client Signature:________________________________________________________
Witness Signature:_______________________________________________________
Date:___________________________________________________________________