ASSOCIATED SERVICES
FOR THE BLIND
AND VISUALLY IMPAIRED

P.O. Box 1758
Bensalem, PA 19020

(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, 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

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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 _____

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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 RELASE 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.

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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: _____