N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
**DIVISION OF SERVICES FOR THE BLIND**
**INDEPENDENT LIVING REHABILITATION**

# INDEPENDENT LIVING REHABILITATION APPLICATION

1. NAME _____ 2. INDIVIDUAL NO. _____ 3. SSN _____
4. MAIDEN NAME _____ 5. E-MAIL ADDRESS _____
6. ADDRESS _____ CITY _____ ZIP CODE _____
7. COUNTY _____ CODE _____ 8. DATE OF BIRTH _____ AGE _____
9. PHONE # (H) _____ (C) _____ 10. GENDER MALE ☐ FEMALE ☐
11. DIRECTIONS TO HOME _____

_____

12. RACE White ☐ African American ☐ American Indian ☐ Asian ☐ Pacific Islander ☐
13. HISPANIC/ LATINO _____ 14.LANGUAGE PREFERENCE _____
15. MARITAL STATUS Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Single ☐
16. NUMBER IN FAMILY _____ 17. CONTACT PERSON(S) _____
18. TYPE OF LIVING ARRANGEMENT Alone ☐ w/ Other(s) ☐
19. TYPE OF RESIDENCE Private Residence ☐ Senior/ Retirement Community ☐
Assisted Living Facility ☐ Nursing Home/ Long Term Care Facility ☐
20. REFERRAL DATE _____ 21. REFERRAL SOURCE _____

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22. VISUAL IMPAIRMENT Totally Blind (LP or NLP) ☐ Legally Blind ☐ Severe Visual Impairment ☐
23. VISION Right _____ Left _____ 24. FIELDS Right _____ Left _____
25. MAJOR CAUSE OF VISUAL IMPAIRMENT Macular Degeneration ☐ Diabetic Retinopathy ☐ Glaucoma ☐
Cataracts ☐ Other ☐
26. NON-VISUAL IMPAIRMENTS Hearing Impairment ☐ Cognitive/ Alzheimer's Disease ☐
Depression/ Mood Disorder ☐ Cancer ☐ Cardiovascular Disease/ Strokes ☐
Diabetes ☐ Other Major Geriatric Concerns ☐ Bone/ Muscle/ Skin/ Joint ☐

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27. FAMILY INCOME
Wages (NET) _____ General Assistance _____
SSDI _____ Other Public Support _____
SSI _____ **Total Family Income** _____
TANF _____ **Excess Income*** _____
OASI _____

***If there is excess net monthly income or assets, DSB-4040 required if services based on need are to be provided.**

Income Eligible: Yes ☐ No ☐

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28. MEDICAL INSURANCE COVERAGE AT APPLICATION Yes ☐ No ☐ Applied ☐
29. MEDICAL INSURANCE THROUGH WORK Yes ☐ No ☐ Not Working ☐
30. MEDICARE Applied ☐ Receiving ☐ None ☐ If Receiving, Medicare Number _____
Indicate Type: Inpatient Hospital ☐ Physician & Outpatient Hospital ☐ Both Inpatient & Outpatient ☐
31 .MEDICAID Applied ☐ Receiving ☐ None ☐ If Receiving, Medicaid Number _____
32. WORKER'S COMPENSATION Yes ☐ No ☐ Number _____
33. PRIVATE INSURANCE Yes ☐ No ☐
34. PRIVATE INSURANCE NAME _____ POLICY _____

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35. INDEPENDENT LIVING NEEDS _____

_____

36. LOW VISION NEEDS _____

_____

37. MOBILITY NEEDS _____

_____

38. COMMENTS _____

_____

39. DO YOU WANT TO REGISTER TO VOTE OR CHANGE YOUR REGISTRATION? Yes ☐ No ☐

**I am applying for services and acknowledge receipt of information of consumer's procedure for appeals.**

_____ _____

**Independent Living Rehabilitation Counselor** **Date**

**Applicant** **Date**