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

INDEPENDENT LIVING SERVICES PROGRAM ASSESSMENT AND PLAN

SECTION I. IDENTIFYING DATA

Client's Full Name	Race	Sex	DOB	Marital Status	Social Security #

Address:		Educ. Completed:	
City:		State:	Zip:
Client's Phone #:		Eligibility Date:	
Alternate Phone #:		Annual Review Date: (if receiving In-Home Aide Services- Level I)	
Directions to Client's Residence:			

Client's Spouse ☐ Parent ☐ Guardian ☐ (Select Relationship to Client)

Address: (if different from client's)	
Phone Number(s): (if different from above)	

DISABLING CONDITIONS
Attach copy of eye report and other pertinent data

Visual	Other Medical

Support Persons, Organizations, and Other Resources Involved with Client

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SECTION II. ASSESSMENT OF CLIENT'S NEEDS AND SERVICE PLAN

AREA OF NEED		SERVICES PLANNED	SERVICES CODE
A. Communication			
1. Reading			
2. Writing			
3. Telephone			
4. Correspondence			
B. Personal Skills			
1. Telling Time			
2. Clothing Identification			
3. Labeling			
4. Money Management			
5. Sewing/ Clothing Repair			
6. Personal Grooming			
7. Social/ Leisure Skills			
C. Home Management			
1.Kitchen and Eating Techniques			
2. Laundry/ Ironing			
3. Cleaning			
D. Low Vision/ Eye Care			
E. Orientation and Mobility Skills			
F. Education/ Consultation			
G. Other			

SSBG SERVICE PLAN GOAL

1
☐ Personal Self-Sufficiency

2
☐ Preventing or Reducing Inappropriate Institutional Care

3
☐ Preventing or Remedying Abuse, Neglect, or Exploitation

SECTION III. REFERRALS FOR ADDITIONAL SERVICES

Refer Clients to:	Date	Date
☐ Independent Living Rehabilitation Counselor	______	______
☐ Nursing Eye Care Consultant	______	______
☐ Orientation and Mobility Specialist	______	______
☐ Directory Assistance Exemption	______	______
☐ Library Services	______	______
☐ Radio Reading Services	______	______
☐ Consumer/ Support Group	______	______
☐ Register for the Blind	______	______
☐ Registered to Vote/ Change your Registration	______	______
☐ Other (specify)	______	______
______________________	______	______
______________________	______	______
______________________	______	______

NOTES:

SECTION IV. STATEMENTS AND SIGNATURES

B. I, the undersigned, ____________________ give/ ____________________ do not give my permission to the Social Worker for the Blind (undersigned) to release my name to the Lions' Club.

B. I, the undersigned, have been informed of my rights and responsibilities. I have participated in the development of this Plan and it has been read to me. I agree to these services.

______________________	
Social Worker for the Blind	**Client (Parent/ Guardian)**
______________________	______________________
Date	Date

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SECTION V. OPTIONAL

AUTHORIZATIONS			
Number	**Item**	Date **Ordered**	**Date Delivered**

NOTES: