Blind & Vision Rehabilitation Services of Pittsburgh

WHAT PROGRAM ARE YOU APPLYING FOR:

☐ **SESSION 1**
July 8 2019 - July 26 2019
Our first session helps students develop and strengthen the essential skills necessary for them to achieve a greater level of independence in our Adjustment to Blindness Training Program. Areas of instruction include orientation and mobility, safe cooking techniques, grooming, and maintaining a home or apartment. Students also benefit from classes in exercise, nutrition and health care, and leisure activities.
Evenings are spent with peers enjoying a variety of activities, such as Camp-Kon-O-Wee, Kennywood Park, a Pittsburgh Pirates Baseball game, movies in the park and much more!

☐ **SESSION 2**
July 29 2019- August 16 2019
Our second session incorporates Assistive Computer Training with Employment Support Services. Students will spend half their day learning about and using devices that will prepare them for college or employment. Our instructors will work with each student individually to help them develop their skills while they train on the latest computer equipment and software. The other half of the day will be focused on employment opportunities. Our students will work at area businesses developing techniques and tools to be successful in a work setting. Past experiences have included the Pittsburgh Food Bank, the Children's Museum, Library for the Blind and Physically Handicapped, and our industries program at BVRS.

☐ **BOTH SESSIONS**

Eligibility Criteria:

1. Students must be registered with their local Bureau of Blindness and Visual Services (BBVS) Agency and have all required paperwork submitted before acceptance into the program and referral form completed by counselor
2. Students must have a diagnosis of visual impairment
3. Student must be between the ages of 14-21
4. Students must demonstrate a basic level of personal care and an interest in increasing independence
5. Students must be interested and willing to participate in all areas of the CCAP program including work experience, dorm living, technology, traveling , team building and recreation
6. Students must be able to commit to attending the program in its entirety
7. Current eye report
8. Current IEP
9. Current Physical (Please use attached form)

If there are any questions about the program/s or the application, please contact:
Bonnie Rizzino
412-368-4400 ext 2246
brizzino@pghvis.org

APPLICANT INFORMATION:

Name: ______________________________________

Date of Birth: ________________________________

Age: _____________________

Gender: __________________

Address: ____

Applicant Phone Number: ______________________________

Applicant e-mail:______________________________________

EYE CONDITION:

Cause of vision loss: _________________________________

Totally blind or light perception only: ____________________________

Some usable vision: ________________________________

Legally blind ________________________________

Visual acuity: ____________________________

HEALTH INFORMATION:

*See attached Rehabilitation Program Medical Evaluation

*See attached Medical Release Form

MOBILITY:

Who is student's TVI instructor: ____

Contact information: ____

Who is student's O&M instructor: ____

Contact information: ____

*See attached Release of Information

EDUCATION:

School: ____

Grade: ____

District: ____

Continued

INDEPENDENT LIVING SKILLS:

Have you ever participated in an overnight program? If so, which program(s)?

____

____

I. Please answer the following:

a. What breakfast foods have you prepared?

____

____

b. What lunch foods have your prepared?

____

____

c. What dinner foods have you prepared?

____

____

d. What three-homemaking tasks would you like to learn?

____

____

II. Please check all that apply:

a. Is your home stove:

- ☐ Electric
- ☐ Gas
- ☐ Dial
- ☐ Push-Button

b. Is your home microwave:

- ☐ Touch
- ☐ Dial

c. Which of the following cause you problems?

- ☐ Setting Appliance Controls
- ☐ Turning Cooking Foods
- ☐ Washing Dishes
- ☐ Following Package Directions
- ☐ Ironing
- ☐ Hand Sewing
- ☐ Measuring Ingredients
- ☐ Determining Doneness
- ☐ Cleaning Table/Counter
- ☐ Doing Laundry
- ☐ Changing Bed Linen
- ☐ Vacuuming

d. Which of the following cause you difficulty?

- ☐ Bathing
- ☐ Shaving
- ☐ Oral Hygiene
- ☐ Identifying Clothing
- ☐ Pouring Liquids
- ☐ Reading/Setting Watch
- ☐ Retrieving and Replacing Money in Wallet
- ☐ Applying Make-Up
- ☐ Hair Care
- ☐ Hanging/Folding Clothing
- ☐ Cutting Food
- ☐ Spreading
- ☐ Personal Care
- ☐ Nail Care
- ☐ Dessert Eating
- ☐ Dialing Phone
- ☐ Identify Money/Coins

Continued

e. Please check the tasks that are difficult for you:

- ☐ Emptying trash
- ☐ Organizing room
- ☐ Measuring (linear)
- ☐ Plugging in an electrical device
- ☐ Changing a light bulb
- ☐ Ladder safety
- ☐ Cleaning tasks, such as: ☐ bathtub ☐ sink ☐ dusting ☐ vacuum
- ☐ Recognition and use of household tools, such as: ☐ scissors ☐ hammer ☐ screwdriver
- ☐ Anything else?

____

f. How do you shop?

☐ With Family ☐ Independently ☐ I do not shop

g. Do you have a checking account? ☐ Yes ☐ No

i. If yes, do you maintain the check register? ☐ Yes ☐ No

h. Do you have a savings account? ☐ Yes ☐ No

i. Are you registered with the Library of Congress' Talking Book Program?

☐ Yes ☐ No

i. If yes, do you have a playback unit?

ii. If yes, what model? ______________________

j. Do you have a digital recorder? ☐ Yes ☐ No

i. If yes, what model? ______________________

k. Do you have writing guides? ☐ Yes ☐ No

i. If yes, please describe them:

____

l. How would you describe your travel skills?

____

____

m. Please mark yes or no to the following that apply:

i. I use a long cane

ii. I use an adapted cane

iii. I use a wheelchair

iv. I use a walker or rolling walker

v. Other ______________________________

Continued

ASSISTIVE TECHNOLOGY:

Please list current assistive technology you use:

a) At home:

____

____

b) In school:

____

____

c) In the community:

____

____

What kind of cell phone or other devices do you have?

____

____

____

WORK HISTORY and/or INTERESTS:
(Please complete only if you are participating in our 2nd session)

List previous volunteer or work experiences:

____

____

____

List your top 3 job or career interests:

1. ____
2. ____
3. ____

List 3 things you do well:

____

____

____

Continued

What are your plans after graduation?

____

____

____

What is your dream job?

____

____

____

CONTACT INFORMATION:
(Parent/ Guardian/ Emergency)

Name: _______________________________

Relationship: ____

Phone Number: __________________________________

E-Mail: _____________________________________

Name: _______________________________

Relationship: ____

Phone Number: __________________________________

E-Mail: _____________________________________

Bureau of Blindness and Visual Services (BBVS) Counselor Information:

BBVS Counselor's Name: _______________________________

Office/County: ____

Phone Number: __________________________________

E-Mail: _____________________________________

Continued

Whom should we contact if we need more information about the applicant?

Name: ________________________________

Phone Number: ___________________________________

E-Mail: ______________________________________

Please read/complete the following attached document:

- ☐ Rehabilitation Program Medical Evaluation
- ☐ Medical Release Form
- ☐ Release of Information
- ☐ Consent to Leave Premises
- ☐ Consumer Rights and Responsibilities
- ☐ Business Consent for Use and Disclosure of Protected Health Information
- ☐ HIPPA Notice of Privacy Practices and Privacy Practices Notice
- ☐ Consent and Release for Publicity

*Please submit application as early as possible, deadline is **May 4th, 2018**.

*All required information and paperwork must be submitted before acceptance.

Please send completed application to:

Email: brizzino@pghvis.org
Bonnie Rizzino
Case Manager, Blind and Vision Rehabilitation Services of Pittsburgh

Fax: 412-368-4090
ATTN: Bonnie Rizzino
BVRSP CCAP

Mail: Blind and Vision Rehabilitation Services of Pittsburgh
ATTN: Bonnie Rizzino
1816 Locust Street
Pittsburgh, PA 15219

Blind & Vision Rehabilitation Services of Pittsburgh

HEADQUARTERS
1816 Locust Street
Pittsburgh, PA 15219

412-368-4400
800-706-5050
TDD: 412-368-4095
Fax: 412-368-4090

www.bvrspittsburgh.org

PBA INDUSTRIES DIVISION
1816 Locust Street
Pittsburgh, PA 15219

Fax: 412-325-7500

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Dear Physician,

Your patient will begin a residential program at Blind and Vision Rehabilitation Services of Pittsburgh. We respectfully request that this form be completed before your patient can begin the program.

In order for us to provide appropriate medical care, we will need your evaluation. Your input could have a significant bearing on your patient's ability to participate in our programs and also in our approach to rehabilitation.

Please include a business card, letterhead, or stamp with contact information should the need arise for me to contact your office.

We appreciate your cooperation!

Sincerely,

Bonnie Rizzino

Bonnie Rizzino

Case Manager

Blind & Vision Rehabilitation Services of Pittsburgh

1816 Locust St.
Pittsburgh, PA 15219
ph. (412) 368-4400
fax (412) 368-4090 (**Attn. Martha Burgoon**)

Rehabilitation Program Medical Evaluation

(TO BE SIGNED AND COMPLETED BY PHYSICIAN)

Name: ____ **DOB**: ________________________

Address: ______________________________________ **Allergies**: ________________________________

______________________________________ ________________________________

Pre-existing medical conditions and/or surgeries:

____
____
____

Vision History: ____

Immunizations:

Hep B	
Polio	
Hib	

DTaP/Td	
Pneumoccal	
MMR	

Chicken Pox	
TB	

Medications: ____
____
____
____

T ____________ P ____________ BP ____________ R ____________ WT ____________ HT _____________

	N	ABN	Notes
Skin			
HEENT			
Neck			
Thyroid			
Lymph nodes			
Veins/Carotid			
Chest			
Lungs			
Heart			
Abdomen			
Genitalia			
Rectal			
Extremities			
Joints			
Clubbing/Cyanosis			
Peripheral Pulse			
Edema			
Neurological			

Continued

The above patient can participate in the following activities:

Extended outdoor walking (2 or more blocks)	Yes: _______	No: _______
Use cardio fitness machines	Yes: _______	No: _______
Balance exercises	Yes: _______	No: _______
Stretching exercises	Yes: _______	No: _______
Chair exercises	Yes: _______	No: _______
Lift weights	Yes: _______	No: _______

Any restrictions on any of the above?

____

____

____

____

____

____
Physician's Signature

____
Date

Blind & Vision Rehabilitation
Services of Pittsburgh

MEDICAL RELEASE FORM

There may be occasions when an emergency will arise involving your family member which will require the provision of certain medical and/or psychiatric services while they are at the agency.

In such cases, our staff will make every effort to contact you and discuss the matter with you. However, the situation may require immediate attention or we may be unable to reach you at that time.

Therefore, we ask that you sign the statement which gives your permission for our staff to take necessary steps in case of such emergency.

I give permission for BLIND AND VISION REHABILITATION SERVICES OF PITTSBURGH to act in my behalf in securing medical services for:

____
(Child/Dependent Name)

These services include taking the client to the emergency room of a hospital, hospitalizing the individual if necessary, and authorizing laboratory tests and x-rays.

Signed: ______________________________

Relationship: ___________________________

Witnessed by: __________________________

Date: ______________________________

Blind & Vision Rehabilitation Services of Pittsburgh

BLIND/VISUALLY IMPAIRED SUMMER PROGRAM
Release of Information

Date:______________________

In order to provide the most appropriate and consistent summer program for your child, Blind & Vision is requesting your permission to share educational information and records of your child with __________________________ and The Bureau of
(School District)
Blindness & Visual Services and Office of Vocational Rehabilitation.

Thank you for your cooperation in this matter.

I, _________________________, give my permission for Blind and Vision
(Parent/Guardian)
Rehabilitation Services, Bureau of Blindness & Visual Services, Office of Vocational Rehabilitation and the ______________________________to release the following
(School District)
information regarding my child, ____________________________________ to the
(Child's Name)
above listed agencies during the 2019-2020 school year.

Specifically, the information to be shared would be the following:

*Initial all that apply

______eye reports
______Educational Functional Vision Assessment
______Learning Media Assessments
______Individualized Education Plan
______other

Signature_______________________________________ Date ___________
(Parent/Guardian)

Blind & Vision Rehabilitation
Services of Pittsburgh

CONSENT TO LEAVE PREMISES

Your son or daughter will be taught skills and techniques that may enable them to travel independently in many environments. If they are able to master these skills and techniques, they will have the opportunity to travel independently to various places in the local community, to travel on public transportation, to shop in a shopping mall and perhaps to go into metropolitan Pittsburgh. Your signature below indicates that this has been explained to you, questions regarding this matter have been answered to your satisfaction, and you agree or do not agree that your son or daughter be allowed to leave Blind & Vision Rehabilitation Services unescorted.

I hereby ☐grant ☐deny

permission for ________________________________ to leave the confines of BLIND AND VISION REHABILITATION SERVICES OF PITTSBURGH unescorted.

I understand that the staff may, at its discretion, restrict unescorted outside trips. Other than the Blind & Vision Rehabilitation Services staff, ___________________________ has my permission to leave the premises with:

1. ____
2. ____
3. ____
4. ____
5. ____

Please print Name: ____________________________________
Parent/Legal Guardian

Signature: ____
Parent/Legal Guardian

Witnessed by: ____

Date: ____

Blind & Vision Rehabilitation
Services of Pittsburgh

CONSUMER
RIGHTS AND RESPONSIBILITIES

As a Client of Blind & Vision Rehabilitation Services of Pittsburgh:

1. You have the right and responsibility to be fully involved in the development, review and any changes to your Service Plan.

2. You have the right to receive a copy of your Service Plan.

3. You have the responsibility to cooperate in carrying out your plan by keeping your appointments and attending your instructional sessions on a regular basis.

4. You have the responsibility to notify appropriate agency staff when you are unable to keep scheduled appointments.

5. You have the right to expect Blind & Vision Rehabilitation Services of Pittsburgh to maintain confidentiality of information obtained in the process of providing services.

6. You have the right to be consulted before your case is closed.

7. You have the right to request an appointment or call your Blind & Vision Rehabilitation Services of Pittsburgh Case Manager to discuss a problem or grievance. If you are still dissatisfied with the services you are receiving or you are being denied services, you may request a review as per Blind & Vision Rehabilitation Services of Pittsburgh Policies and Procedures.

8. You have the right to review the information in your case record as well as an interpretation of the information by appropriate professional personnel. You may request a copy of such information in writing through your Case Manager.

CONSUMER
RIGHTS AND RESPONSIBILITIES cont.

Blind & Vision Rehabilitation Services of Pittsburgh, as a Service Agency:

1. We have the right to establish criteria for participation in Blind & Vision Rehabilitation Services of Pittsburgh programs and services.

2. We have the responsibility to provide quality and expeditious service without regard to race, religion, sex, age, color, creed, national origin or ability to pay.

3. We have the responsibility to provide services in a timely manner and on a regular scheduled basis.

4. We have the responsibility to maintain confidentiality of consumer information obtained during the course of providing services.

5. We have the responsibility to provide services in a drug-free, alcohol free, and smoke free environment. As an agency, we do not tolerate physical or sexual harassment.

6. We have the right to terminate services if a client violates any environment policies during the provision of services.

I have read the above and understand the rights and responsibilities as listed.

______________________________________ ____________

Client Signature **Date**

Blind & Vision Rehabilitation
Services of Pittsburgh

BUSINESS CONSENT FOR THE USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to the use and disclosure of my Protected Health Information by Blind & Vision Rehabilitation Services of Pittsburgh, their staff, and their business associates in order to carry out treatment, payment, or health care operations. I understand that Protected Health Information means my health information, which is individually identifiable (e.g. name, social security number, date of birth, diagnosis etc.).

I understand that uses and disclosures for treatment, payment, or health care operations include, but are not limited to:

- Using or disclosing health information in order to make a diagnosis or provide treatment;
- Submitting health information to the health insurance company in order to obtain payment for treatment or services rendered;
- Sharing health information with other health care or service providers in which I have a Relationship; and
- Reviewing my health information during quality assessment activities.

I understand that I have a right to receive a more detailed explanation of Blind & Vision Rehabilitation Services of Pittsburgh privacy practices prior to signing this Consent. I also understand that the terms of the HIPAA Notice of Privacy Practices may change and that I may request a revised notice by contacting the person listed below and that a revised notice will be posted in the waiting areas of Blind & Vision Rehabilitation Services of Pittsburgh facilities.

I understand that I have a right to request that Blind & Vision Rehabilitation Services of Pittsburgh restrict how it uses and discloses my Protected Health Information in order to carry out treatment, payment, or health care operations. I understand that Blind & Vision Rehabilitation Services of Pittsburgh is not required to agree to the restrictions, but that if Blind & Vision Rehabilitation Services of Pittsburgh agrees, the restriction is binding.

I understand that I have the right to revoke this Consent, but must do so in writing. I also understand that a revocation applies to uses and disclosures made after the revocation.

Signed: ________________________________ Date: ___________________

Name (Print): ___________________________

Witness: ________________________________

Human Resources
Blind & Vision Rehabilitation Services of Pittsburgh
1816 Locust Street
Pittsburgh, PA 15219
(412) 368-4400

Blind & Vision Rehabilitation
Services of Pittsburgh

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Organization's Pledge To You

This notice is intended to inform you of the privacy practices followed by Blind & Vision Rehabilitation Services of Pittsburgh. An explanation of the federal privacy rights afforded to you will also be included.

Blind & Vision Rehabilitation Services of Pittsburgh often needs access to health information in order to provide services. We want to assure individuals receiving services through Blind & Vision Rehabilitation Services of Pittsburgh that we comply with federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to health information to comply with the privacy practices below.

Uses and Disclosures of Health Information

Health Care Operations Blind & Vision Rehabilitation Services of Pittsburgh may use and disclose health information in order to perform administrative functions such as quality assurance activities, resolution of internal grievances, and evaluation of services. We may use and disclose your health information to remind you of an appointment or to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Payment Blind & Vision Rehabilitation Services of Pittsburgh may use and discloses health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party and to coordinate benefits with other third party providers.

Treatment Blind & Vision Rehabilitation Services of Pittsburgh may use and disclose health information to give you medical treatment or services. We may share your health information with other health care personnel who are involved in providing your health care. We may share health information about you with people outside Blind & Vision Rehabilitation Services of Pittsburgh who perform services related to your treatment, or to provide follow-up care to you.

As Permitted or Required by Law Blind & Vision Rehabilitation Services of Pittsburgh may use and disclose health information without your written authorization in certain special situations where the law permits, and under some circumstances requires us to do so. Subject to Pennsylvania law, Blind & Vision Rehabilitation Services of Pittsburgh may share your health information under circumstances, including, but not limited to, (i) when law

requires that we report information about suspected abuse, neglect or domestic violence, or related to suspected criminal activity, or in response to a court order, (ii) when we are required to collect or report health information for public health activities or health oversight activities, or (iii) when we must do so in order to prevent serious harm to you or others, or (iiii) for fund raising activities, certain limited marketing activities and research activities.

Pursuant to your Authorization When required by law, Blind & Vision Rehabilitation Services of Pittsburgh will ask for your written authorization before using or disclosing your health information. If you choose to sign the authorization, you can later revoke that authorization at any time to cease any further uses or disclosures. However, we are unable to take back any information that we have already shared with your permission.

INDIVIDUAL RIGHTS

Right to Inspect and Copy In most cases, you have the right to inspect and copy the health information Blind & Vision Rehabilitation Services of Pittsburgh maintains about you. If we deny your request, we will provide you with written reasons for the denial and explain your right to have the denial reviewed. If you request copies, Blind & Vision Rehabilitation Services of Pittsburgh will charge you $0.10 (10 cents) for each page. Your request to inspect or review your information must be submitted in writing to the person listed below.

Right to an Accounting of Disclosures You have the right to receive a list of instances where Blind & Vision Rehabilitation Services of Pittsburgh has disclosed health information about you for reasons other than treatment, payment, or health care operations. Your request for an accounting must be submitted in writing to the person listed below.

Right to Amend If you believe that the information within your records is incorrect or if important information is missing, you have the right to request that Blind & Vision Rehabilitation Services of Pittsburgh correct the existing information or add the missing information. If we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request. Your request for an amendment must be submitted in writing to the person listed below.

Right to Request Restrictions You may request that Blind & Vision Rehabilitation Services of Pittsburgh limit the health information we use or

disclose to others for treatment, payment, or health care operations. Blind & Vision Rehabilitation Services of Pittsburgh will consider your requests, but is not legally obligated to agree to those restrictions. Your request for a restriction must be submitted in writing to the person listed below.

Right to Request Confidential Communications You have the right to request to receive confidential communications containing your health information. Blind & Vision Rehabilitation Services of Pittsburgh is required to accommodate reasonable requests. For example, you may ask that Blind & Vision Rehabilitation Services of Pittsburgh contact you at your place of employment or send communications regarding treatment to an alternate address or in a desired format. Your request for confidential communications must be submitted in writing to the person listed below.

Our Legal Duties

Blind & Vision Rehabilitation Services of Pittsburgh is required by law to protect the privacy of your health information, provide this notice about health information practices, and follow the health information practices that are described in this notice.

Blind & Vision Rehabilitation Services of Pittsburgh reserves the right to change this notice and its policies at any time and make new provisions effective for health information we already maintain. We will post a copy of the current notice in the waiting areas of Blind & Vision Rehabilitation Services of Pittsburgh facilities. Blind & Vision Rehabilitation Services of Pittsburgh will offer you a copy of our current notice each time you present you present for health services. You can also request a copy of our current notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Human Resources
Blind & Vision Rehabilitation Services of Pittsburgh
1816 Locust Street
Pittsburgh, PA 15217
(412) 368-4400

Complaints

If you are concerned that Blind & Vision Rehabilitation Services of Pittsburgh has violated your privacy rights, or you disagree with a decision Blind & Vision Rehabilitation Services of Pittsburgh made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services – Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information.

You will not be penalized for filing a complaint.

Blind & Vision Rehabilitation
Services of Pittsburgh

PRIVACY PRACTICES NOTICE

ACKNOWLEDGEMENT FORM

My signature below acknowledges that I have received and read the Privacy Practices Notice regarding Blind & Vision Rehabilitation Services of Pittsburgh's policies with respect to the treatment, use, and disclosure of individually identifiable health information and their legal duties with respect to that information.

Signature: ______________________________

Name (Printed): _________________________

Witness: ________________________________

Date: __________________________________

Blind & Vision Rehabilitation
Services of Pittsburgh

CONSENT AND RELEASE FOR PUBLICITY

I hereby give to **Blind & Vision Rehabilitation Services of Pittsburgh**, to its nominees, agents and assigns, my free and unlimited consent and permission, waiving all claims for any compensation by reason thereof of for any damages by reason thereof, to use, publish, republish or exhibit in the furtherance of its work, with or without identification of me by name, any photographs and/or videos that my include my image, picture or voice.

And to disseminate statements referring to me in conjunction with **Blind & Vision Rehabilitation Services of Pittsburgh** and to authorize any newspaper, company or other organization to use, publish, republish, or exhibit said image with or without identification of me by name ant to publish or disseminate statements referring to me in conjunction therewith in the promotion of **Blind & Vision Rehabilitation Services of Pittsburgh** or any of its activities.

Witness my signature this _______ day of ___________, 2019.

Signature: ____

Address: ____

If the individual is a minor, one or both of his/her parents or legal guardians should sign the following.

I hereby consent and agree, individually, and as parent or legal guardian of __________________________________ (a minor), to all terms and provisions stated above.

Witness my signature this _______ day of ___________, 2019.

Signature: ____

Address: ____

Relationship to Minor: ____________________________________