Catholic Charities
Education Services
for Blind and
Visually Impaired Children

Most Rev. James T. Ruggieri, *President* **Jared S. des Rosiers,** ***Chair*** **Stephen P. Letourneau,** *Chief Executive Officer*
Kirsten Connelly, *Program Director*

Dear Parent/CDS/Special Education Director:

Maine's Division for the Blind & Visually Impaired (DBVI) is mandated to provide services to children with a vision impairment (birth to completion of high school) which affects their ability to learn. Education Services for Blind & Visually Impaired Children (ESBVIC) a program of Catholic Charities Maine (CCM) is contracted by DBVI to provide these education services.

The Teachers of Blind & Visually Impaired (TVIs) may provide the following services: assessment of vision & corresponding implications for learning, direct teaching of necessary disability-specific related skills, and/or consultation to schools & families. TVI's providing services to children are part of the Early Childhood Team, the Individualized Education Program Team, or the 504 process. Upon receiving a completed application packet, the ESBVIC supervisor assigns the child to a TVI who will then provide an assessment to help determine the functional implications of the vision loss.

It is essential for determination of services from ESBVIC and DBVI that all the documents included in the referral packet are returned. Please note that ESBVIC needs a **medical eye report** from an eye doctor so we can proceed in processing the student's application. If you do not have the doctor's report, please make sure the releases are signed, and we will request the report.

Information to return in the enclosed, self addressed, stamped envelope

1) **Application Form**
2) **Medical Eye Report – from Child's eye doctor**
3) **Client Consent to Email Usage in Treatment**
4) **Authorization to Disclose Information for Ophthalmologist**
5) **Authorization to Disclose Information for CDS/SCHOOL**
6) **Authorization to Disclose Information for DBVI**
7) **Authorization to Disclose Information to APH**

If you have questions, please call Zachary Pike at (207) 523-4133 or toll free 1-888-941-2855. Send faxes to (207) 282-1694.

Sincerely,

Kirsten Connelly, Program Director
(207) 653-5197
kconnelly@ccmaine.org

Education Services for Blind & Visually Impaired Children
Catholic Charities Maine
420 Cumberland Avenue, Portland ME 04101
207-523-4133 1-888-941-2855 x5416 FAX 207-282-1694

APPLICATION FOR EDUCATION SERVICES FOR BLIND & VISUALLY IMPAIRED CHILDREN

Student's Name _____ **Birth Date:** ___/___/_____

Home Address: _____**Town:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Parents or Legal Guardian Name: _____ **E-Mail Address:** _____

School: _____ **Grade:** _____ **Teacher**_____

Referral source:_____ **Contact:** _____ **Phone Number:** _____

Address: _____ **Town:** _____ **Zip:** _____

Name & address of your child's eye physician or optometrist:

Name: _____ **Date of last visit:** _____ **Phone Number:** _____

Address: _____ **Town:** _____ **Zip:** _____**Fax**_____

What have you, as a parent/guardian, noticed about your child's use of vision? _____
_____
_____

Family doctor:_____ **Phone Number:** _____**FAX Number:** _____

Address: _____ **Town:** _____ **Zip:** _____

Describe any other disabilities your child may have: _____

Other Service Providers: _____

Education Services for Blind and Visually Impaired Children is funded by the Division for the Blind & Visually Impaired Education Services through funding from the State of Maine. Eligibility is determined without regard to sex, race, creed, age, color, or national origin. There are no residency requirements, durational or other, which would exclude from services an otherwise eligible individual who is living in the state.

____ My child has an existing IEP/IFSP/504 plan. I understand and authorize Catholic Charities Maine as a contracted entity of State of Maine, Department of Labor, Division for the Blind and Visually Impaired to share information pertinent to the education of my child with the school district. **Initial**_____
____ My child does not have an existing plan

Acknowledgement of Receipt of Notice of Privacy Practices

Client Name:_____
By signing below, I acknowledge that I have been given a copy of
Catholic Charities Maine's Notice of Privacy Practices.

Signature of Client/Personal Representative: _____

Print Name of Client/Personal Representative: _____
Date: ____/____/____ Time: ____:____ ☐ AM ☐ PM

Signature of Parent or Guardian: _____ **Date:** _____

Please return this completed form, along with signed permission slips and doctors report to: ESBVIC; Catholic Charities Maine; 420 Cumberland Ave, Portland ME 04101

Catholic Charities
Education Services
for Blind and
Visually Impaired Children

CLIENT CONSENT TO E-MAIL USAGE IN TREATMENT

Name of Client _____

IMPORTANT INFORMATION ABOUT USE OF E-MAIL

Because e-mail is not a secure or confidential medium, we cannot guarantee that any e-mail that you may send to us will remain confidential. While we consider your communications private and confidential and do not disseminate information about you without your permission, our administration reserves the right to monitor e-mail usage and so others might therefore see the text of your message. For this reason, we offer the following information to help you decide on the best method for communicating with us:

If you are in any way concerned about the contents of your email being read by someone other than the intended staff person, you might want to consider phoning or dropping by our office instead.

When we respond to e-mail, we will respond to the address from which it is sent. If you do not wish others who may have access to the e-mail account you are using to also have access to our response, please consider another means of contacting us.

While we check our email often during the regular office hours, you need to know that your e-mail message may not be received immediately. E-MAIL IS NOT RECOMMENDED AS A METHOD FOR CONTACTING US IN AN EMERGENCY. If time is of a particular concern for you, please phone the office instead.

It is important for you to know that Internet messages, i.e. e-mail messages, are public communication and are not considered private. All communications, including text and images, can be subpoenaed and can be disclosed to law enforcement or other third parties without prior consent of the sender or the receiver.

Finally, our highest priority is to serve you, however, at times of high demand or problems with our computer system, we may not be able to respond quickly or effectively by e-mail.

We hope that the above information is helpful to you as you consider how to best contact our office. In honoring your confidentiality, we believe it is important that you understand the limitation of our use of e-mail and Internet technology at this time.

I hereby consent to communicate with Catholic Charities Maine employees regarding my services and treatment using e-mail. In granting this permission, I have read or have had read to me, and understand the information described above.

*I give permission for staff of Education Services for Blind and Visually Impaired Children to email school staff/other providers regarding my child's educational goals as stated in the IFSP/IEP/504 plan.

Signature of client or guardian _____ Date _____

Guardian/Client email address _____

Signature of Program Staff _____

Program _____ Date _____

****

Revocation: I wish to revoke the consent given above with the understanding that my revocation will not affect anyone who takes action in reliance upon this Consent Form without notice of revocation.

_____ _____

(Signature of _____ client, _____ parent, _____ guardian) Date

_____ _____

Signature of Witness Date

CATHOLIC CHARITIES MAINE
Education Services for Blind and Visually Impaired Children
420 Cumberland Avenue, Portland, ME 04101
AUTHORIZATION TO DISCLOSE INFORMATION

Client Name: _____ Client Date of Birth: _____

I understand that a copy of this form will be released with my records.

Catholic Charities Maine may **RELEASE TO: Ophthalmologist:** _____

_____
(Address)

_____
(City, State, Zip Code)

_____ _____
(Phone Number) (FAX Number)

Information pertaining to:	Information for the following purposes:
Eye Condition/Most recent eye exam report	**Service to my child**
Education	**Service to my child**
☐ Do ☐ Do Not include health records from other sources.	

Catholic Charities Maine may **OBTAIN FROM:**

Ophthalmologist: _____

Information pertaining to:	Information for the following purposes:
Eye Condition/Most recent eye exam report	**Services from ESBVIC**
School/Work concerns	**Services from ESBVIC**
☐ Do ☐ Do Not include health records from other sources.	

This Authorization expires automatically upon the following case, event or condition (not to exceed one year): Date:_____

Required Statements: I understand that: (1) CCME cannot withhold treatment if I refuse to sign this Authorization, unless it relates to research-related treatment or treatment provided solely to create and disclose health information to a third party; (2) I may review my records prior to release and refuse to disclose some or all of them; (3) I may revoke all or part of this Authorization at any time by notifying CCME as provided in its Notice of Privacy Practices, except to the extent that action has already been taken in reliance on this Authorization; (4) In some cases a refusal or revocation may result in improper diagnosis or treatment, denial of insurance coverage or other similar consequences; (5) A disclosure of information carries with it the potential for re-disclosure if the recipient is not subject to the state or federal confidentiality rules; and (6) I may have a copy of this Authorization.

Release: I hereby release CCME from all liability and all claims relating to the release of this information.

DATE: _____ _____ _____
Signature of Client/Personal Authorized Representative Print Name

_____
Specify Relationship for Authorized Representation

DATE: _____ _____ _____
Witness Print Name

Catholic Charities
Education Services
for Blind and
Visually Impaired Children

Most Rev. James T. Ruggieri, *President* **Jared S. des Rosiers,** *Chair* **Stephen P. Letourneau,** *Chief Executive Officer*
Kirsten Connelly, *Program Director*

Federal Quota Medical Addendum

Dear_____,

You are receiving this form because we need further clarification to determine the level of visual functioning for a student. "The Federal Act to Promote the Education of the Blind", enacted by Congress in 1879, requires us to have current, eye health care reports from an Optometrist, Ophthalmologist, or Neurologist on file in order to be eligible to be counted in the Federal Quota program, and to access learning materials from American Printing House for the Blind. Since eye reports vary widely by doctor and by child given the unique circumstances of each case, would you please provide clarification to determine whether this student meets the Federal guidelines of legal blindness or functional blindness in order to be counted in the Federal Quota program.

Student Name: _____ **DOB:** _____

DOCTOR'S OFFICE TO COMPLETE THIS SECTION: Please check ONE box below

Based on Exam Date: _____, regarding the above mentioned student, in your professional judgment, do you feel this person:

☐ **Functions better than 20/200 corrected, in their best eye** *(Snellen* **equivalent)**

☐ **Meets the Definition of Blindness - "MDB"**
As defined in The Act: "Central visual acuity of 20/200 or less in the better eye with correcting glasses or a peripheral field so contracted that the widest diameter of such field subtends an angular distance no greater than 20 degrees,"

OR

☐ **Functions at the Definition of Blindness - "FDB"**
As defined in The Act: "When visual performance is reduced by a brain injury or dysfunction when visual function meets the definition of blindness as determined by an eye care specialist or neurologist. Students in this category manifest unique visual characteristics often found in conditions referred to as neurological, cortical, or cerebral visual impairment."

_____ _____
Doctor Signature **Date**

Doctor's Name (please print): _____

Eye Doctor's Office: Please return this form **with the eye report:**
Kirsten Connelly
Program Director
Education Services for Blind and Visually Impaired Children
Catholic Charities Maine

CATHOLIC CHARITIES MAINE
Education Services for Blind and Visually Impaired Children
420 Cumberland Avenue, Portland, ME 04101
AUTHORIZATION TO DISCLOSE INFORMATION

Client Name: _____ Client Date of Birth: _____

I understand that a copy of this form will be released with my records.

Catholic Charities Maine may **RELEASE TO CDS/School:** _____
Address: _____
City, State, Zip Code: _____
Phone number _____
Fax Number: _____

Information pertaining to:	Information for the following purposes:
Eye Condition/Most recent eye exam report	**Service to my child**
Education	**Service to my child**
☐ Do ☐ Do Not include health records from other sources.	

Catholic Charities Maine may **OBTAIN FROM:**

School/CDS name: _____

Information pertaining to:	Information for the following purposes:
Eye Condition/Most recent eye exam report	**Services from ESBVIC**
School/Work concerns	**Services from ESBVIC**
☐ Do ☐ Do Not include health records from other sources.	

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Release: I hereby release CCME from all liability and all claims relating to the release of this information.

DATE: _____ _____ _____
Signature of Client/Personal Authorized Representative Print Name

_____
Specify Relationship for Authorized Representation

DATE: _____ _____ _____
Witness Print Name

CATHOLIC CHARITIES MAINE
Education Services for Blind and Visually Impaired Children
420 Cumberland Avenue, Portland, ME 04101
AUTHORIZATION TO DISCLOSE INFORMATION FOR DBVI

Client Name: Client Date of Birth:

I understand that a copy of this form will be released with my records.

Catholic Charities Maine may **RELEASE TO: Division for Blind & Visually Impaired**
☒ Central office
☐ Orientation and Mobility Instructor
☐ Vocational Rehabilitation

45 Commerce Drive
Augusta , ME 04333-0150
Phone: 207 623-7954 Fax: 207-879-7553

Information pertaining to:	Information for the following purposes:
Eye Condition/Most recent eye exam report	**Service to my child**
Education	**Service to my child**
☐ Do ☐ Do Not include health records from other sources.	

Catholic Charities Maine may **OBTAIN FROM:**

Division for Blind & Visually Impaired, ☐ Central Office ☐ Orientation and Mobility Instructor ☐ Vocational Rehabilitation

Information pertaining to:	Information for the following purposes:
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DATE: _____ _____ _____
Signature of Client/Personal Authorized Representative Print Name

_____
Specify Relationship for Authorized Representation

DATE: _____ _____ _____
Witness Print Name

In order to register my child with Catholic Charities Maine ESBVIC and the American Printing House for the Blind (APH*), I hereby authorize Catholic Charities Maine, ESBVIC to share my child's personally identifiable information as follows: Last Name, First Name, Middle Name, Date of Birth, School District, Grade Placement, Visual Function, Primary and Secondary Reading Medium, and cross reference of siblings also registered (to prevent duplication of registration).

I, _____ (print name), certify that I am the parent(s)/guardian(s) of _____ (student's full name), whose date of birth is _____ (student's complete date of birth), and that s/he is a dependent. I understand that this release will remain in effect unless I revoke it in writing. I further understand that I can revoke this release at any time by sending an email to Kirsten Connelly kconnelly@ccmaine.org

_____ _____

Parent Signature **Date**

***APH is a nonprofit organization for the blind. According to the Federal "Act to Promote the Education of the Blind", all students who meet the definition of blindness can receive specialized textbooks and accessible materials through the APH Federal Quota Program.**

Education Services for Blind & Visually Impaired Children
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1-888-941-2855 ext 5416 | Tel (207) 523-4133 | Fax (207) 282-1694
esbvic@ccmaine.org | www.ccmaine.org/ESBVIC