



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 contact Zachary Pike, Administrative Assistant,
email: zpike@ccmaine.org | phone: (207) 523-4133 (toll free 1-888-941-2855) | fax: (207) 282-1694.

Sincerely,

A handwritten signature in black ink, appearing to read "Kirsten Connelly".

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

Education Services for Blind & Visually Impaired Children

420 Cumberland Avenue, Portland, ME 04101

1-888-941-2855 ext 5416 | Tel (207) 523-4133 | Fax (207) 282-1694

esbvic@ccmaine.org | www.ccmaine.org/ESBVIC

APPLICATION

Student's Name		Birth Date:	
Physical Address:	Town:	Zip:	
Mailing Address: <input type="checkbox"/> Same as above	Street:	Town:	Zip:
Home Phone:	Work Phone:	Cell Phone:	
Preferred Number to call:	<input type="checkbox"/> Home	<input type="checkbox"/> Work	<input type="checkbox"/> Cell
Parents or Legal Guardian Name:		E-Mail Address:	

School:	Grade:	Teacher	Referral source:
Contact:	Email address:	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 State of Maine Division for the Blind & Visually Impaired. 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 offered 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 / Guardian: _____ Date: _____

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/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/guardian: _____

Date: _____

Witness signature: _____

Date: _____

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
 (enter Provider's name): _____

Address:

City:

ST:

Zip:

Phone #:

Fax #:

<p>Information pertaining to:</p> <p><u>Eye Condition/Most recent eye exam report</u></p> <p><u>Education</u></p> <p><input type="checkbox"/> Do <input type="checkbox"/> Do Not include health records from other sources.</p>	<p>Information for the following purposes:</p> <p><u>Service to my child</u></p> <p><u>Service to my child</u></p>
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Catholic Charities Maine may **OBTAIN FROM:** Ophthalmologist Name:

<p>Information pertaining to:</p> <p><u>Eye Condition/Most recent eye exam report</u></p> <p><u>School/Work concerns</u></p> <p><input type="checkbox"/> Do <input type="checkbox"/> Do Not include health records from other sources.</p>	<p>Information for the following purposes:</p> <p><u>Services from ESBVIC</u></p> <p><u>Services from ESBVIC</u></p>
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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.

Client / Personal Authorized Representative – Printed Name:

Client/Rep Signature:

Relationship to client

Date:

Witness (Printed Name):

Witness Signature:

Date:

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: _____ ST: _____ Zip: _____

Phone #: _____ Fax #: _____

<p>Information pertaining to:</p> <p><u>Eye Condition/Most recent eye exam report</u></p> <p><u>Education</u></p> <hr/> <p><input type="checkbox"/> Do <input type="checkbox"/> Do Not include health records from other sources.</p>	<p>Information for the following purposes:</p> <p><u>Service to my child</u></p> <p><u>Service to my child</u></p> <hr/> <hr/>
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Catholic Charities Maine may **OBTAIN FROM**: School/CDS Name:

<p>Information pertaining to:</p> <p><u>Eye Condition/Most recent eye exam report</u></p> <p><u>School/Work concerns</u></p> <hr/> <p><input type="checkbox"/> Do <input type="checkbox"/> Do Not include health records from other sources.</p>	<p>Information for the following purposes:</p> <p><u>Services from ESBVIC</u></p> <p><u>Services from ESBVIC</u></p> <hr/> <hr/>
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Release: I hereby release CCME from all liability and all claims relating to the release of this information.

Client / Personal Authorized Representative – Printed Name: _____

Client/Rep Signature: _____ Relationship to client _____ Date: _____

Witness (Printed Name): _____ Witness Signature: _____ Date: _____

AUTHORIZATION TO DISCLOSE INFORMATION FOR DBVI (Division for Blind & Visually Impaired)

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

<p>Information pertaining to:</p> <p><u>Eye Condition/Most recent eye exam report</u></p> <p><u>Education</u></p> <hr/> <p><input type="checkbox"/> Do <input type="checkbox"/> Do Not include health records from other sources.</p>	<p>Information for the following purposes:</p> <p><u>Service to my child</u></p> <p><u>Service to my child</u></p> <hr/>
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Catholic Charities Maine may **OBTAIN FROM:** Division for Blind & Visually Impaired

Central Office Orientation and Mobility Instructor Vocational Rehabilitation

<p>Information pertaining to:</p> <p><u>Eye Condition/Most recent eye exam report</u></p> <p><u>School/Work concerns</u></p> <hr/> <p><input type="checkbox"/> Do <input type="checkbox"/> Do Not include health records from other sources.</p>	<p>Information for the following purposes:</p> <p><u>Services from ESBVIC</u></p> <p><u>Services from ESBVIC</u></p> <hr/>
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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.

Client / Personal Authorized Representative – Printed Name: _____

Client/Rep Signature: _____ Relationship to client _____ Date: _____

Witness (Printed Name): _____ Witness Signature: _____ Date: _____

AUTHORIZATION TO DISCLOSE INFORMATION

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, (parent/guardian), 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/Guardian 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.