Center for Independent Living of Central PA
Deafblind Living Well Services
Application to Receive Services

If your completing this application as an electronic version with Assistive Technology, please use the "Table" navigation commands. Control+Alt+Arrow Keys

Date:		
Consumers Full Name:		
Nick names:		
Street Address:		
Apt #/Suite #		
City:		
State:	Pennsylvania	
Zip Code:		
County:		
Telephone #:		
Cell Phone #:		
Text #: (if different from Cell phone)		
VP/TTY #:		
Work Phone #:		
Email address:		
Gender:		
Date of Birth:		
Age:		
Are you a Veteran?	Yes	NO

How do you identify yourself?	(Please check one)
Deafblind	
Hard of Hearing/Blind	
Hard of hearing/Visually Impaired	
Deaf/Low Vision	
How did you hear about DBLWS?	(please check all that apply)
Agency:	
Presentation:	
Family/Friend:	
Brochure/Flyer:	
Medical Professional:	
Social Media/Website:	
School/College/University:	
Referred by: (Name of Agency):	
Referred by: (Name of Staff):	

Living Arrangements?	(Please check one)
Single or with others	
spouse/partner/significant other	
Group Home	
Assisted Living/Institution	
Unknown	
Other: (please describe)	
Employment Status? (Please check one)	(Please check one)
Not currently Working but have worked in the past	
Currently working Part Time	
Currently working Full Time	
Retired	
Supported Employment	
Other: (please describe)	
How do you communicate?	(Check all that apply)
Sign Language	
Tactile Sign Language	
Print on palm	
Communication Cards or Board	
Voice	
Other: (please describe)	

What method of correspondence works best for you? (Check all that apply)

E-mail

Braille

Large Print (what font is best for you):

Text files

US Mail

What accommodations do you use? (Check all that apply)

White Cane

Service animal

TTY/Videophone/Captel Phone/Relay

DeafBlind communicator

Closed Circuit TV (CCTV)

Mobility device (wheelchair, scooter, walker, support cane)

Assistive Listening Devices

low vision equipment (magnifiers, telescopes)

Other: (please explain)

Usual Mode of Transportation -	(Please check all that apply)
Depend on Friends/Family	
Paratransit	
Ride Share Service/Taxi	
Public Transportation	
Drive Self	
Other (please describe)	
Support Service Provider (SSP)	(check one that applies)
I do not currently have a Support Service Provider	
I do currently use a SSP/helper/Attendant/assistant	
Provide name and contact information:	
Voter Registration	(Please check one)
Are you a registered voter in Pennsylvania?	Yes

Consumer Signature	
Date	

Application completed by, if not consumer:	(please check one)
Friend/Family	
CILCP Staff	
BVRS/BVS/ODHH Staff	
Signature of Individual completing application, if not consumer:	
Date:	

Center for Independent Living of Central PA

DeafBlind Living Well Services (DBLWS)

207 House Avenue, Suite 107

Camp Hill, PA 17011

E-mail: DBLWS@cilcp.org

TTY: 717.737.1335/Toll Free: 800.829.7404 or Videophone: 717.255.0124

CILCP Staff use only

Date application received in office: (Date)

Checklist of information provided to consumer:

HIPAA Notice

Voter Registration Form Grievance Policy

Release of Information, if needed Training Manual

CILCP Staff Signature)

Date

NOTES: