

APPLICATION FOR INDEPENDENT LIVING SERVICES

Division of Service to the Blind & Visually Impaired

Name SSN

Address City

State Zip Home Phone Work Phone

I wish to apply for services that will result in increasing my ability to live independently. I understand that my eligibility for services will be determined within 60 days. I authorize the Division to gather and release information to determine my eligibility for independent living services and to assist in determining the services necessary which will assist in my independence.

The exchange of information may include cooperating with other Departments in State government and the Social Security Administration. I further authorize the Division to release/supply to the Department of Human Services and their divisions, the following information: name, social security number, date of birth, race, sex, demographic data, and program status. This information is necessary for the purpose of collecting, reporting, analyzing data and to facilitate access to services/programs offered by the Department of Human Services. Other than these situations, information will only be released to sources upon my individual written consent. I understand that I may restrict the release of information.

Requested restrictions and/or comments:

I have access to an information sheet explaining the Client Assistance Program. If I am dissatisfied with any action in regard to the furnishing or denial of services, I understand I may file a request for an administrative review, mediation or a fair hearing by contacting:

Older Blind Rural Independent Living Specialist
Division of Service to the Blind and Visually Impaired
3800 East Highway 34
c/o 500 East Capitol
Pierre, SD 57501-5070

I acknowledge that this form was accessed and completed electronically. I will be provided a copy of my application if requested. Please print, sign the form and mail to the address listed above.

Signature of Applicant or Authorized Representative

Application Date