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MISSOURI DEPARTMENT OF SOCIAL SERVICES
REHABILITATION SERVICES FOR THE BLIND

APPLICATION FOR SERVICES

PREVENTION OF BLINDNESS PROGRAM
PO BOX 2320
JEFFERSON CITY, MO 65102-2320
TELEPHONE: (573) 751-3428 OR (800) 592-6004 #8
FAX: (573) 751-1281

NAME		SPOUSE (OR PARENT IF UNDER 21)		
ADDRESS (STREET OR RR., APT. #)	CITY	STATE	ZIP CODE	COUNTY
BIRTHDATE	SEX	MARITAL STATUS		TELEPHONE NUMBER

RESIDENCY (REQUIRED INFORMATION)

Are you present in Missouri and intend to stay here? ☐ Yes ☐ No

Are you either a US citizen or lawfully present in the United States? ☐ Yes ☐ No

FINANCIAL INFORMATION (IMPORTANT, COMPLETE ALL BLANKS)

LIST ALL MEMBERS IN HOUSEHOLD (CONTINUE ON BACK IF NEEDED)	RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER	EMPLOYER NAME OR INCOME SOURCE (IF MORE THAN 1 SOURCE PER INDIVIDUAL, WRITE ON 2ND LINE)	AMOUNT (MONTHLY)

NOTE: If income is from self employment or farming, please attach copies of last tax return and schedule C or schedule F.

TOTAL NUMBER IN HOUSEHOLD	TOTAL INCOME AVAILABLE TO HOUSEHOLD MONTHLY ▶	GROSS (BEFORE TAXES)	NET (AFTER TAXES)

SAVINGS AND RESOURCES OTHER THAN HOME. REQUIRED INFORMATION

LIST TYPE & AMOUNT. IF $0, WRITE "NONE" COMPLETE THIS BLANK

(SAVINGS ACCOUNTS, C.D.'S, DIVIDENDS, INVESTMENTS, TRUSTS, ETC.)

MEDICAL INSURANCE COVERAGE

A. PRIVATE INSURANCE, HOSPITAL	SURGICAL	B. TITLE XIX (MEDICAID) ☐ YES ☐ NO
NAME(S) OF OTHER AGENCIES PROVIDING SERVICES		MEDICAID CARD NUMBER
I REQUEST THAT MY EYE EXAMINATION APPOINTMENT BE SCHEDULED WITH (CHECK ONE) ☐ NO PREFERENCE ☐ OPHTHALMOLOGIST (M.D., OR D.O.) ☐ OPTOMETRIST		MEDICARE **PART A** ☐ YES ☐ NO **PART B** ☐ YES ☐ NO **PART D** ☐ YES ☐ NO

MEDICAL INFORMATION

HISTORY OF EYE CONDITION AS GIVEN BY APPLICANT

EYE CARE SPECIALIST'S NAME	ADDRESS	TELEPHONE NUMBER
DATE OF LAST EXAM (IF WITHIN LAST 2 YEARS, PLEASE COMPLETE ENCLOSED INFORMATION RELEASE FORM)	DIAGNOSIS	
DEGREE OF VISION ▶	W/OUT CORRECTION R.E.	L.E.
	WITH CORRECTION R.E.	L.E.
OTHER DISABILITIES	**SERVICE(S) NEEDED**	
IF MEDICAL INFORMATION SECTION IS COMPLETED BY DOCTOR PLEASE HAVE DOCTOR SIGN HERE ▶		

APPLICATION FOR SERVICES

I hereby apply for services of Rehabilitation Services for the Blind. I authorize Rehabilitation Services for the Blind to obtain information from your records relative to my application. I certify that the above information is a true statement of my present financial status.

APPLICANT'S SIGNATURE (SIGNATURE IS REQUIRED)	SOCIAL SECURITY NUMBER (REQUIRED)	DATE
X		
REFERRED BY	TELEPHONE NUMBER	DATE

IS THIS A FAMILY SUPPORT DIVISION OFFICE REFERRAL? ☐ YES ☐ NO