Catholic Charities
Education Services
for Blind and
Visually Impaired Children

Most Rev. Robert P. Deeley, J.C.D., *President* **David Madore,** *Chair* **Stephen P. Letourneau,** *Chief Executive Officer*
Jeff Tiner, *Chief Operating Officer* **Nancy Moulton,** *Program Director*

Dear Parent/CDS/Special Education Director:

Maine's Division for the Blind & Visually Impaired (DBVI) is mandated to provide services to children (birth to completion of high school) with a vision impairment which affects their ability to learn. Education Services for Blind & Visually Impaired Children (ESBVIC) a program of Catholic Charities Maine 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, 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 processUpon receiving a completed application packet, the ESBVIC supervisor reviews the information to determine if there is evidence that the child has been diagnosed by an eye doctor with a visual impairment. If the report indicates a visual impairment, they will assign the child to a TVI who will then determine the functional implications of the vision loss.

. As a contract provider for the Division for the Blind and Visually Impaired, information will be shared with DBVI. Our program is also a mandated reporter to Maine's Department of Health and Human Services of any cases of abuse or neglect if that occasion should ever arise.

It is essential for determination of services from ESBVIC and DBVI that all of the documents are returned. In particular, please note that ESBVIC needs a **medical eye report** from the doctor so we can proceed in processing the student's application. If you do not have the doctors report please call your eye doctor for a copy of the most recent 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 ESBVIC**
5) **Authorization to Disclose Information for DBVI**

If you have questions please call Sue Auger at (207) 299-1936 or toll free 1-888-941-2855 x5436. Send faxes to (207) 282-1694.

Sincerely,

Nancy E. Moulton

Nancy Moulton, Program Director
(207) 592-4760
nmoulton@ccmaine.org

Education Services for Blind & Visually Impaired Children
Catholic Charities Maine
P.O. Box 645 Biddeford ME 04005
207-592-4760 1-888-941-2855 x5416 FAX 207-282-1694

APPLICATION FOR EDUCATION SERVICES FOR BLIND & VISUALLY IMPAIRED CHILDREN

Student's Name _____ Birth Date: ___/___/_____ Soc Sec Number: _____-_____-_____

Home Address: _____Town: _____ Zip: _____

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

E-Mail Address: _____

Parents or Legal Guardian Name: _____
(first & last name(s) of parents)

CDS Sites/School: _____ Grade: _____

CDS/School Contact: _____ Phone Number: _____

Address: _____ Town: _____ Zip: _____

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

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

Address: _____ Town: _____ Zip: _____

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/health/medication problems your child may have: _____

_____

Other Service Providers: _____
Agency making referral: _____
Is this child under foster care with the State of Maine Dept. of Health & Human Services? ( ) Yes ( ) No

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; P.O. Box 645 Biddeford ME 04005

CATHOLIC CHARITIES MAINE
Education Services for Blind and Visually Impaired Children
PO Box 645, Biddeford, ME 04005

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: 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.	

AIDS/HIV/STD/TB: If this released information contains any reference to any of the following, the release of that information is authorized by my initials: **HIV:** _____ **AIDS:** _____ **STDs:** _____ **TB:** _____
(Initial) (Initial) (Initial) (Initial)
I have been advised of the potential implications of releasing HIV/AIDS information.
Please Note: A line that does not contain an initial should be interpreted as a refusal to release such information.

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 MAINE
Education Services for Blind and Visually Impaired Children
PO Box 645, Biddeford, ME 04005
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: School/CDS name**

_____
(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**
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Specify Relationship for Authorized Representation

DATE: _____ _____ _____
Witness Print Name

CATHOLIC CHARITIES MAINE
Education Services for Blind and Visually Impaired Children
PO Box 645, Biddeford, ME 04005

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 SHS 150
(Address)
Augusta, ME 04333-0150
(City, State, Zip Code)
623-7954 287-5292
(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:**

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

Information pertaining to:	Information for the following purposes:
Eye Condition/Most recent eye exam report	**Services from ESBVIC**
School/Work concerns	**Services from ESBVIC**
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(Initial) (Initial) (Initial) (Initial)
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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
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