Department of Health Services
Division of Public Health
F-22468 (12/2025)

State of Wisconsin

Application for Services with the Office for the Blind and Visually Impaired

Instructions: Complete and sign this form. Completion of this form is voluntary. Personally identifiable information collected on this form is confidential and will only be used in determining eligibility for services.

Consumer name: _____

Address or PO box: _____

City: _____ ZIP code: _____

County: _____

Phone number (include area code): _____

Email: _____

Birthdate: _____

Sex: ☐ Male ☐ Female

Race/ethnicity: _____ Marital status: _____

Source of referral: _____

Alternate contact person section

Name – Alternate contact: _____

Relationship: _____

Phone number: _____

List your type of residence (e.g., house, apartment, assisted living facility, nursing home):

_____

Do you live alone or with others? ☐ Live alone ☐ With others

Are you a U.S. Veteran? ☐ Yes ☐ No

What is your visual impairment?

How does your visual impairment impact your ability to complete daily living tasks/activities?

Name – Eye doctor: _____

Date of last exam: _____ Date of onset: _____

Please list any other concerns or conditions.

Do you have Medicaid? ☐ Yes ☐ No ☐ Unsure

Are you enrolled in a long-term care program such as Family Care or IRIS? ☐ Yes ☐ No ☐ Unsure
If yes, answer the following questions.

Name of MCO: _____

Name of care manager: _____

Care manager phone number: _____