Iowa Department for the Blind
Application Release for Services

I, (client) _____

of (address) _____

formally apply for services from the Iowa Department for the Blind (IDB). I understand that, as an applicant for services, I will receive only those services required to find out if IDB can assist me to prepare for, secure, retain or regain employment. My signature below indicates that I intend to obtain and retain full-time employment, or part-time employment if appropriate, that is in line with my strengths, abilities, capabilities, interests and informed choice.

I understand that this form will serve as my signed release for IDB to obtain vision information necessary to determine eligibility.

I hereby authorize IDB and its representative to contact the Social Security Administration and request and receive a social security query containing any and all information relative to my SSI and/or SSDI payments, Medicare and/or Medicaid, Iowa Workforce Development and/or Department of Labor for wage verification.

If I have a Ticket to Work from the Social Security Administration, I acknowledge that by signing this document, if determined eligible, IDB will take my ticket and I will be enrolled in the Ticket to Work program.

All information I provide to IDB, must be kept confidential. If I'm unable or unwilling to provide medical, psychological or vocational information, services provided by IDB may be delayed or denied.

I understand that the eligibility determination for my application must be made within 60 days. To be determined eligible for services you must meet the following criteria:

1. You must have a visual impairment of legal blindness, functional blindness or a degenerative eye disorder that will lead to legal blindness.
2. Which for you constitutes a substantial impediment to employment.
3. You can benefit in terms of an employment outcome.
4. You must also require vocational rehabilitation services in order to prepare for, secure, retain or regain employment.

If you and your counselor disagree about the provision of services, your plan, or other issues, you have a number of options to address the disagreement. You may pursue all or some of these options.

- Talk to your counselor to see whether you can resolve the disagreement.
- Talk to the person who supervises your counselor.
- Seek assistance through the Client Assistance Program (CAP). You can reach CAP at Client Assistance Program, Office of Persons with Disabilities, Lucas State Office Building, Des Moines, Iowa 50319; voice and TTY 1-800-652-4298.
- Ask for mediation. In mediation, an impartial third person works with you and your counselor to resolve the issue.
- Ask for a formal hearing before an impartial hearing officer. You have 120 days after your counselor or other Department staff informs you about a decision to ask for a formal hearing.

Programs administered by the Iowa Department for the Blind are provided in compliance with Title VI of the Civil Rights Act, the Iowa statutes on civil rights and Section 504 of the Rehabilitation Act of 1973, as amended. The Department serves all eligible applicants regardless of race, color, creed, gender, national origin, religion, disability, or age.
For further information about the above options, to request mediation or formal hearing, or other questions, contact:

Iowa Department for the Blind
524 Fourth Street
Des Moines, Iowa 50309-2364
1-800-362-2587
515-281-1333

I am aware of the availability of the Client Assistance Program (CAP). CAP is a neutral, third-party agency which offers clients information and assistance in the following areas: understanding IDB services; advice about available services; request for a review of an agency decision; resolving problems in the delivery of services or with IDB staff. CAP can be contacted at any time during VR process at 1-800-652-4298 toll free.

We at the Department for the Blind look forward to working with you and being a part of your future success.

Contact Person Outside the Home (Name and Phone Number):

_____

Client Signature: _____

Date: _____

Representative (where appropriate): _____

Counselor Signature: _____

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