SECTION 500: REPORTING REQUIREMENTS

REVISED: 09/29/10

FORM I-9: EMPLOYMENT ELIGIBILITY VERIFICATION [F-1]

PURPOSE: The purpose of Form I-9 is to document that each new employee (both citizen and non-citizen) is authorized to work in the United States.

PREPARED BY:

The employee will complete Section 1 and the DSB employee will **assist** the individual/consumer (who is the employer) if necessary in completing Section 2 and remaining items. The form will be completed **before** the employee (reader or in-home aide) begins working. A new I-9 must be completed on each new employee of the recipient of In-Home Level I. Go to webpage www.uscis.gov , click on immigration forms then scroll down to the I-9 form for "usable" forms and updates.

INSTRUCTIONS:

SECTION 1: Employee Information and Verification

1. The employee will print or type his/her full name, address, date of birth and Social Security Number.

a. All employees whose present names differ from their birth names, because of marriage or other reasons must print or type their birth names in the appropriate space.

b. Employees whose names change after employment verification are responsible for reporting these changes to their employer (DSB Individual/ consumer).

2. Immigration Status:

a. Check the appropriate block to indicate citizenship status (either U.S. citizen, non-citizen, lawful permanent resident, or alien).

b. If the second block (non-citizen) is checked, please see instructions supplied with the form.

c. If the third block (lawful permanent resident) is checked, enter the alien registration number **or** admission number **and** the expiration date of that status if it expires.

d. If the fourth block (alien) is checked, enter the alien registration number **or** admission number **and** the expiration date of that status if it expires.

3. Signature and Date:

a. The employee must sign and date the form.

b. If an individual assists the employee with preparing this form, the preparer must certify the form by signing it and printing or typing his/her complete name and address, and date the document.

SECTION 2: Employee Review and Verification

The DSB employee will assist, if necessary, the employer **(DSB individual/consumer)** be responsible for examining evidence of identity and employment eligibility, and:

1. Check the appropriate box in List A **or** check one box from List B **and** one box from List C;

2. Record the document title, issuing authority, document identification number and expiration date, if any; and

3. Record the type of form if not specifically identified in the list.

NOTE: The DSB employee is responsible for assisting, if necessary, the employer **(DSB individual/consumer)** in re-verifying employment eligibility of employees whose employment eligibility documents carry an expiration date.

Name changes of employees which occur after preparation of Form I-9 are to be recorded on the form by lining through the old name, printing the new name and the reason (such as marriage), and dating and initialing the changes. Do not delete or erase the old name in any manner. The DSB employee may assist the employer **(DSB individual/consumer)** with this if necessary.

CERTIFICATION SECTION:

1. The employer (DSB individual/consumer) must sign the CERTIFICATION in section 2. If the employer signs with a mark, then the DSB employee may write in the employer's name beside the mark and then at the bottom of the I-9, write in the words "witness to signature" and the DSB employee should sign his/her own name.

2. The DSB employee may assist with other items under CERTIFICATION if necessary.

SECTION 3: Updating and Re-verification

The DSB employee may also assist the employer **(DSB individual/consumer)** if necessary, in completing this section if an update or re-verification needs to be made. The employer must sign his/her own name but the DSB employee could be a witness if he/she signs with a mark.

The DSB employee will write the date the form is mailed to the DHHS Controller's Office and the Chief of Vocational Rehabilitation Field Services or Chief of Independent Living Services on the copy of the I-9 to be kept in the case record.

DISTRIBUTION:

Original: Employer **(DSB individual/consumer)** and it should be kept with important papers as Immigration Officials could request to see it.
Copies: **DHHS Controller's Office with first bill**, Program Chief, Case Record

Form I-9, Employment Eligibility Verification

FORM 2678 EMPLOYER APPOINTMENT OF AGENT [F-2]

PURPOSE:

To allow eligible individuals/consumers who employ readers or in-home aides to designate the NC Division of Services for the Blind (DSB) as their agent to report these employee's Social Security taxes (FICA) to the Internal Revenue Service (IRS).

All eligible individuals/consumers who employ **readers or in-home aides** for In-Home Level I: Home Management services are liable for reporting and paying FICA (Federal Insurance Contribution Act) commonly known as Social Security taxes each quarter. Employers must also provide the employee with a Form W-2 at the end of each year. Realizing that the filing of these reports would impose an additional burden on eligible individuals/consumers, the State Office has developed a system to do the reporting for them.

PREPARED BY:

The DSB employee will ensure that Form 2678 is completed for each eligible individual/consumer who receives reader services or In-Home Aide Level I: Home Management services from DSB.

INSTRUCTIONS:

Complete only one form for each eligible individual/consumer even if the eligible individual/consumer is receiving services from more than one reader or In-Home Aide during the same time period.

Part 1: Why are you filing this form: Check the appropriate box to indicate if you (eligible individual/consumer) are filing to appoint an agent or filing to revoke an existing appointment.

Part 2: Employer or Payer Information: If you want to appoint an agent or revoke an appointment, complete this part.

1. Employer Identification Number: Enter eligible individual's/consumer's Social Security number. Whenever possible, copy the nubmer directly from the individual's/consumer's Social Security card to minimize the chance of error.

2. Employer's or Payer's Name: Enter eligible individual's/consumer's full name (first name, middle initial and last name).

3. Trade Name (if any): Enter eligible individual's/consumer's trade name.

4. Address: Enter eligible individual's/consumer's most current street address, city and five-digit zip code.

5. Forms for which you want to appoint an agent or revoke the agent's appointment to file: Leave blank. Do not check any of these spaces.

Eligible Individual/consumer signs the form in the appropriate box.
Eligible Individual/consumer dates the form in the appropriate box.

Eligible Individual/consumer prints their name in the appropriate box.
Eligible Individual/consumer enters their title in the appropriate box (if applicable).
Eligible Individual/consumer enters the best daytime phone in the appropriate box.

Part 3: Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.

6. Agent's Employer Identification Number: Already completed. Do not write in these spaces.

7. Agent's Name: Already completed. Do not write in these spaces.
Agent's Address: Already completed. Do not write in these spaces.

8. Trade Name (if any): Leave blank. Do not write in these spaces.

9. Address: Already completed. Do not write in these spaces.

Check the box if the employer is a disabled individual/consumer or other welfare recipient receiving home-care services through a state or local program.

NC Services for the Blind director signs the form in the appropriate box.
NC Services for the Blind director dates the form in the appropriate box.
NC Services for the Blind director printes their name in the appropriate box.
NC Services for the Blind director enters their title in the appropriate box.
NC Services for the Blind director enters the bet daytime phone in the appropriate box.

DISTRIBUTION:

Original: Program Chief- forwards to DSB Director
DSB Director signs and dates on page 2 and returns to Program Cheif
Copy: Case Record

Form-2678, Employer/Payer Appointment of Agent

DSB-2205-A REFERRAL FOR LOW VISION EVALUATION [F-3]

PURPOSE:

The DSB-2205-A is used to refer a consumer to the Nursing Eye Care Consultant (NECC) for low vision. It includes the consumer's identifying information and provides additional information to assist the NECC in performing the evaluation. The service plan of the referring worker (SWB, Independent Living Rehabilitation Counselor or Rehabilitation Counselor) should be attached to form DSB-2205-A and the recent eye report. The referral will not be accepted without an eye report.

PREPARED BY:

DSB-2205-A is prepared by the Social Worker for the Blind, Independent Living Rehabilitation Counselor when there is a need to refer the consumer to the NECC. It should be prepared in duplicate with the original sent to the NECC and a copy kept in the case record.

INSTRUCTIONS:

Name: Enter the consumer's full name.

Address: Enter the complete address, including street number, city and zip.

County: Enter the consumer's county of residence.

Eligibility Information: How recommended aids will be purchased (self-pay, Block Grant funds, MEC funds, Rehab needs or non-needs case.)

DOB: Enter consumer's month, day and year of birth.

Telephone Number: Enter consumer's area code and telephone number.

Alternate Telephone: Enter a work phone number or that of a friend or relative where the consumer can be reached if not at home.

Contact Person: Enter the name of a friend or relative.

Living Situation: Indicate whether consumer lives alone or with family/friends.

Reason for Referral: Enter the consumer's current need for low vision aids.

Directions: Enter good, clear driving directions from the county DSS or from the NECC's office. Indicate the starting point of the directions.

Education: Enter highest grade completed in school.

Occupation: Enter current occupation if applicable.

Training: Enter any special training the consumer has received.

Work Experience: Enter experience from previous employment.

Visual Acuity: Enter right eye visual acuity beside "OD" and enter left eye visual acuity beside "OS".

Visual Field: Enter right eye visual field beside "OD" and enter left eye visual field beside "OS".

Visual Diagnosis: Enter the eye diagnosis from consumer's eye doctor and also attach an eye report.

Pertinent Medical Problems/Impairments/Comments: Enter any additional physical or visual concerns that may assist the NECC in doing the evaluation. **Indicate if the consumer needs an interpreter for the evaluation. The referral source will arrange this accommodation with the NECC, consumer and interpreter.**

Case Manager Signature: The referral source (SWB, ILR Counselor or Rehabilitation Counselor) signs on this line.

Date of Referral: Enter the date the form is completed and forwarded to NECC.

DSB-2205-A , Referral for Low Vision Evaluation

DSB-2205-B REPORT ON LOW VISION EVALUATION

Name: Enter consumer's full name.

Near Acuity with RX: Enter NECC's findings of near acuity in both OD (right eye) and OS (left eye).

Without RX: Enter NECC's findings without prescription in each eye.

Consumer Complaints/Concerns: Indicate the consumer's needs relating to vision as expressed by consumer as well as any complaints/concerns needing attention of referral source.

Low vision aids recommended should be listed in order of priority with recommendation limited to 2 (due to limited funds) unless there are extenuating circumstances.

Source of Purchase: Indicate vendor that is recommended by NECC.

Aid Suggested: Indicate low vision aid recommended.

Catalog Number: Enter catalog number of aid from recommended vendor.

Price: Enter the price of the aid as listed in latest catalog.

Notes Regarding Visit: The NECC should elaborate on the low vision evaluation, if it appears consumer is a good candidate for low vision aids, and if consumer needs or requests a referral to a low vision specialist. It should be noted if the NECC provides a list of low vision specialists from whom the consumer may choose. It should also be noted if the consumer needs follow-up services and the NECC's plans to address those needs.

GOOD CANDIDATE FOR CCTV EVALUATION: "Y" = Yes, "N" = No.

Contact Date: Initial contact date can be the date of the first written contact by NECC which often explains that referral has been received and telephone contact by NECC will follow shortly for scheduling an appointment.

Evaluation Date: Enter the date of the actual evaluation.

Follow-Up Date: Enter the date of follow-up if this was needed.

Signature of NECC: The Nursing Eye Care Consultant should sign the report on the line indicated.

DISTRIBUTION: The original copy of the NECC's report should be faxed or mailed to the referring source and a copy kept in the office of the NECC.

DSB-2205-B, Report On Low Vision Evaluation

DSB-7001 APPLICATION [F-4]

INSTRUCTIONS:

Field 1 - **Social Security Number**: Enter applicant's/consumer's Social Security Number. If the applicant/consumer does not have a valid SSN, enter his/her temporary consumer number. To assign a temporary SSN: the first two digits are always "99". The third digit will be "7" to represent the ILS Program, the fourth digit represents the geographic area (Area 1, 2, 3 or 4), and the fifth and sixth digits represent the Worker Number. The last three digits will be assigned in sequence by the SWB, beginning with 001, 002, etc.

Field 2 - **Name**: Enter consumer's name-last name, first name and middle initial.

Last: Enter first 15 letters of applicant's/consumer's last name. If last name has more than 15 letters, omit them.

First: Enter first 10 letters of applicant's/consumer's first name. If first name has more than 10 letters, omit them.

Middle Initial: Enter first letter of applicant's/consumer's middle name. If applicant/consumer has more than one middle name, enter data for first middle name only.

Field 3 -**Date of Birth**: (Leave Fields 3, 4 and 5 blank. Electronic Services

Field 4 - **County**: System will automatically complete these fields).

Field 5 - **Vision Status**:

Field 6 - **Application Date**: Enter six-digit code to specify month, day and year that applicant/consumer signed application for Independent Living Services. Use MM, DD, YY format.

Field 7 - **Referral Source**: Enter source of referral. Example: Teacher, neighbor, Dr. Smith, self, etc. Limit to 10 digits.

Field 8 - **Client Status**: Enter two-digit code that specifies the individual's status in the service delivery process. Valid codes are:

Status 00 - Referral

Status 08 - Rejected

Status 10 - Active

Status 32 - Re-opened for short period of time

Status 48 - Closed Unsuccessful

Status 49 - Closed Successful

NOTE: ALL CASES MUST GO INTO "00" STATUS BEFORE MOVING INTO "08" OR "10"

Field 9 - **Status Date**: Enter six-digit code to designate date that individual was placed in his/her current status. Use MM, DD, YY format.

Field 10 - **Worker Number**: Enter four digit worker number assigned to your caseload.

Field 11 - **Eligibility Category**: Enter three-digit code which designates individual's eligibility for independent living services. To determine the correct category, begin at the top of the list below and place individual in first applicable category.

009 - With Regard to Income: an individual who receives services at least one of which has income as a condition eligibility under SBG.

019 - Without Regard to Income: an individual who receives only services available without regard to income and who is in none of the above categories.

099 - Eligibility Not Determined: **can be used only with status "00: Referral".**

Field 12 - **Goal**: Enter one-digit code to indicate consumer's SSBG service goal.

Code 1 = Achieving or maintaining self-sufficiency
Code 2 = Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other
forms or less intensive care.
Code 3 = Preventing and remedying neglect, abuse, or exploitation of persons unable to protect their own interests, or preserving rehabilitation, or re-uniting families.

Field 13 - **In-Home Aide Services**: Level I Home Management Eligibility: Enter "Y" if consumer is eligible for In-Home Level I: Home Management. Leave blank if not eligible.

Field 14 - **Reason**: If the Consumer has applied for In-Home Aide Services and has been determined eligible based on vision, need, income and citizenship/residency but the service cannot be provided for one of the three reasons stated below, then indicate the reason code in this field. **Do not** use this field for someone that the SWB thinks might need the service and might meet the criteria. This field is used to determine our waiting list for In-Home Aide Services in the ESS.

Code 1 - Agency funds not currently available
Code 2 - Unable to find a suitable In-Home Aide
Code 3 - Other

SECTION B: SERVICE PLAN AND ACTION TAKEN

Field 15 - **Service**: List names of independent living services requested by or received by the applicant/consumer. If additional lines are needed, continue on another DSB-7001 and number pages accordingly. Refer to Appendix B in ILS Manual for listing of service names.

Field 16 - **Service Code**: Enter three-digit code for each service requested. Refer to Appendix B in ILS Manual for listing of service codes.

Field 17 - **Approved**: Enter Code 1 if service on corresponding line in Field 15 is approved. Leave blank if other action.

Field 18 - **Denied**: Enter Code 1 if service on corresponding line in Field 15 is denied. Leave blank if other action.

Field 19 - **Modified**: Enter Code 1 if service on corresponding line in Field 15 is modified in any manner. Leave blank if other action.

Field 20 - **Terminated**: Enter Code 1 if service on corresponding line in Field 15 is terminated. Leave blank if other action.

Field 21 - **Reason**: Enter reason code if service on corresponding line in Field 15 is denied, modified or terminated.

Code 1 - Goal met by consumer
Code 2 - Consumer unable to participate in service delivery
Code 3 - Consumer not willing to participate in service delivery
Code 4 - Consumer not eligible for independent living services
Code 5 - Unable to locate consumer
Code 6 - Consumer moved to different service area
Code 7 - Death of consumer

Field 22 - **Effective Date**: Enter six-digit code for effective date of action taken on service approvals, denials, modifications or terminations. Use MM, DD, YY format.

SECTION C. IN-HOME AIDE SERVICES: LEVEL I- HOME MANAGEMENT

Field 23 - **Review Date**: Enter six-digit code to indicate last date of eligibility for consumers receiving In-Home Aide Services: Level I-Home Management. Use MM, DD, YY format.

Non-numeric Field: Use the workspace next to Field 23 Review Date to compute eligibility for In-Home Aide Services: Level I Home Management if service was requested by applicant/consumer. Verification and explanation of computation of income should be in narrative.

SECTION D. EXPLANATION OF ACTION

Use this space to provide written explanation to applicant/consumer pertinent to decision regarding his/her service(s).

If the service request(s) was approved, write "Approved" and the beginning date of service.

If the action being taken is "Denied", "Modified", or "Terminated", cite the reason for the action and specify the appropriate ILS Manual Policy reference. Write out the reason for the code used in Field 21 above.

SECTION E. SIGNATURES AND DATE OF APPLICATION

The statement in this section and the Application Statement on the back of client's copy of the form must be read by or read to, as necessary, the applicant/consumer or his/her representative in an effort to

assure that it is understood by him/her. The client must sign and date the form in the space indicated. If applicant/consumer signs with a mark, the signature of a witness is needed. The witness cannot be the Social Worker for the Blind. The worker will sign in the space provided for the Social Worker for the Blind.

DISTRIBUTION:

White: Data Entry
Canary: Client
Pink: Case Record

DSB-7001 , Independent Living Services Program Application

DSB-1010 REGISTRANT DATA FORM [F-5]

DSB-1010: Registrant Data Form may be prepared by any referral source from information on the DSB-2202: Report of Eye Examination. This form is also used by Social Workers for the Blind to notify the Register Clerk of changes in registrants' situations such as name changes, address changes, county transfers and deletions.

The form is now available on line and information should be entered and then forwarded electronically to the Register Clerk (see Email option in lower right hand corner). The only exception to this is when a person is being added to the Register and then the form should be printed after information has been entered (see print option in lower right corner of form) and medical information should be attached. The DSB-1010 and the medical information should then be mailed to the Register Clerk at Division of Services for the Blind, 2601 MSC, Fisher Building, Raleigh, NC 27699-2601.

Enter the date the form is being prepared and the name of the person submitting the data. Enter in the appropriate block to indicate if the registrant is new, a change of information on an existing registrant, a removal of a registrant or a transfer from one county to another.

1. **Register Number**: If this number is known by the person submitting the data, then the number should be entered.

2. **Social Security Number**

3. **Registrant Name**: Enter the registrant's last name, first name and middle initial.

4. **Sex**: Enter code M for male or code F for female.

5. **Maiden Name**: Enter registrant's maiden name. Leave blank if not applicable or if this information is not available.

6. **Date of Birth**: Enter a two-digit month, two-digit day and four-digit year for the registrant. It is critical that the worker verify the birth date. If the
birth date is unknown, leave the field blank until birth date is obtained and update it at that time.

7. **Area**: Enter a one-digit code to indicate that registrant is being served in Area 1, 2, 3 or 4.

Code 1: Counties served by Asheville and Charlotte District Office
Code 2: Counties served by Winston-Salem District Office
Code 3: Counties served by Fayetteville and Raleigh District Office
Code 4: Counties served by Greenville and Wilmington District Office

8. **County**: Enter a two-digit code for the county using county codes from Appendix H in ILS Manual.

9. **Address**: Enter the registrant's current street address, city, two-digit state code and the zip code.

10. **Telephone**: Enter the registrant's telephone number including the three-digit area code and seven digit number.

11. **In Institution**: Enter a one-digit number code to indicate if registrant is currently in a public or private licensed home or institution.

Code 1: In public or private licensed home or institution
Code 2: Not in an institution

12. **Race/Ethnicity**: Enter "X" in all boxes that apply.

13. **Language Preference**: Enter the two-character code. Default is English.

EN = English, SP = Spanish, AR = Arabic, CA = Cambodian, CH = Chinese, FR = French, FC = French Creole, GE = German, GR = Greek, GU = Gujarati, HI = Hindi, HM = Hmong, HU = Hungarian, IT = Italian, JA = Japanese, KR = Korean, LA = Laotian, MI = Miao, MK = Mon-Khmer, PE = Persian, PO = Polish, PG = Portugese, PC = Portugese Creole, RU = Russian, SC = Serbo-Croation, TA = Tagalog, TH = Thai, UR = Urdu, VI = Vietnamese, OT = Other

14. **Vision Group**: Coded by Register Clerk in State Office.

15. **Hearing Impairment Code**: Complete with one of the following codes.

Blank: Hearing status not known

0: No hearing loss

B/VI Due to Retinitis Pigmentosa with:

1 Mild hearing loss

2 Moderate to severe loss

3 Profound hearing loss

B/VI Due to other causes with:

4 Profound prelingual hearing loss (occurring before 3rd birthday)

5 Profound hearing loss occurring between ages 3-21

6 Profound hearing loss occurring after age 21

7 Moderate to severe hearing loss occurring prior to age 21 8 Moderate to severe hearing loss after age 21

9 Mild hearing loss

16. **Diagnosis**: Coded by Register Clerk in State Office.

17. **Etiology**: Coded by Register Clerk in State Office.

18. **Deceased**: Enter code "Y" if deceased or leave blank.

19. **Remove from Register**: Enter code "Y" if registrant is to be removed.

20. **Reason**: Enter a code indicating the reason for removal from the Register.

Code 1: Death
Code 2: Left North Carolina
Code 3: Vision restored. Attach eye report verifying the improved vision.
Code 6: Unable to locate. This code accepted **only** if all of the following data are reported on the back of the DSB-1010. **If sending the DSB-1010 electronically to the Register Clerk, send an email that includes the following data:**

a. Attempt to contact registrant by telephone, and
b. Letter to registrant has been returned undeliverable and
c. DSS records have been searched (ex. Medicaid and/or Food Stamps and no record of registrant is available).

Code 7: Administrative error; duplicate

21. **Re-add to Register**: If the registrant has previously been on the register but was removed (examples: moved out of state or vision improved) but later needs to be added to the register again, please enter "Y" in the field.

DSB-1010, Registrant Data Form

DSB-7080 CANE REQUEST FORM [F-6]

PURPOSE:

DSB-7080 is used to order canes through the North Carolina Lions Foundation, Inc. **They will provide one cane to a consumer in a one year period**. If the consumer needs more than one cane in a year, he/she may purchase the cane at cost from NCLF.

PREPARED BY:

1. For **first request long cane orders**, the O & M Specialist will submit DSB-7080.

2. For **first request support cane orders**, the SWB will submit DSB-7080. The support cane is often called an orthopedic cane. This cane does double duty as support and identification for visually impaired persons.

3. For **replacement canes** (long and support), the Social Worker for the Blind will submit DSB-7080 with the cane to be delivered by a local Lion.

INSTRUCTIONS:

1. **Client**: Complete all identifying information for individual who will receive cane.

2. **Type of Request**: Check the appropriate block to indicate whether order is a first request or a replacement request.

3. **Type of Cane Requested**: Indicate length specifications according to cane type.

4. **Request Submitted By**: Enter information about person preparing request.

5. **Mail Cane to**: Completed by Lions Foundation.

6. **Measuring for Canes**: Refer to instructions in Orientation and Mobility Manual.

DISTRIBUTION:

Original plus 1 copy to:
North Carolina Lions Foundation, Inc.
PO Box 39
Sherrills Ford, NC 28673
Copy: Consumer Case Record

DSB-7080, Cane Request Form

DSB-7103 INDEPENDENT LIVING SERVICES PROGRAM ASSESSMENT AND PLAN [F-7]

PURPOSE:

DSB-7103 is used to document consumer assessment and service planning. The form will capture consumer identifying information, document assessment of the consumer's daily living skills, and indicate referral to Resource Specialist(s) for specialized training in ILS skills, if needed. The Assessment and Plan will also document services planned by the case manager and the consumer to enable the consumer to achieve the highest possible level of independence in daily living skills.

PREPARED BY:

This form is prepared by the Social Worker for the Blind in the role of Case Manager after he/she has collected all pertinent applicant information, all eligibility requirements have been met by the applicant/consumer and the DSB-7000 and DSB7001 have been completed.

GENERAL INSTRUCTIONS:

1. DSB-7103 must be completed in a timely manner so that service delivery is initiated at the earliest possible time but no later than 15
calendar days after the date the agency notified the consumer of his/her initial eligibility.

2. Case Manager will review the DSB-7103 periodically but at least annually, to insure that all consumer data and service entries are
current, thus reflecting any additional service requests, terminations, etc. recorded on DSB7001: Application.

3. If more space is needed for service planning, use additional sheets of ILS Plan and attach to DSB-7103.

SPECIFIC INSTRUCTIONS:

Section I. Identifying Data

Name: Enter consumer's full name (first, middle and last name).

Race: Enter "White", "African American", "American Indian", "Asian", "Pacific Islander" and/or "Hispanic". Enter all races that the consumer declares.

Sex: Enter "F" for Female or "M" for Male.

Date of Birth: Enter month, day and year of consumer's birth.

Marital Status: Enter "M" for Married, "S" for Single, "D" for Divorce or "W" for Widow/Widower.

Address: Enter consumer's complete address including city, state and zip code.

Education Completed: Enter current grade or highest grade completed.

Consumer's Phone Number: Enter telephone number, if available.

Alternate Phone Number: Enter any other necessary telephone number(s).

Eligibility Date: Enter beginning date for consumer's service eligibility.

Annual Review Date: Enter last date of 12-month eligibility period for consumers receiving In-Home Aide Services: Level I-Home Management.

Directions to Consumer's Residence: Enter driving directions from county department of social services or SWB's office to consumer's residence.

Consumer's Spouse/Parent/Guardian: Enter name of spouse, parent, or guardian, if applicable, and circle relationship to consumer

Address: Enter address of individual listed in category above, if different from consumer's address.

Phone Number: Enter phone number of individual listed in category above, if different from consumer's phone number.

Disabling Condition: Visual: Enter consumer's vision disability.

Other Medical: Enter any additional physical or mental conditions which affect the consumer's ability to function independently.

Support Persons, Organizations, and Other Resources Involved with Consumer: List persons and/or resources which may either create or help remove barriers to the consumer achieving independence. Give a brief description of the person's or resource's involvement with the consumer.

Example 1. Neighbor comes in three times each week to help with chores.

Example 2. Consumer receives a hot lunch through the Meals-on-Wheels.

SECTION II. Assessment of Consumer's Needs and Service Plan

A. From information gathered during the needs assessment, indicate the consumer's area(s) of need. List services planned in order to meet these needs.

B. SSBG Service Plan Goal-Check the appropriate SSBG goal.

SECTION III. Referrals for Additional Services

A. Indicate the Resource Specialist(s) and/or other resources to which the consumer was referred. List the date of referral.

B. List date of referral to Register of the Blind if appropriate.

SECTION IV. Statements and Signatures

A. Statements of Understanding: These statements must be reviewed with the consumer and/or his/her parent or guardian. The consumer or his/her parent or guardian must sign and date the Plan.

B. The Social Worker for the Blind must also sign and date the Plan.

SECTION V. Optional

The worker may use this space to record ILS aids and appliances ordered for the consumer along with dates of authorization, receipt and delivery as well as any other notes that may be beneficial.

DISTRIBUTION:

Original: Case Record
Copy: Each Resource Specialist receiving consumer referral. **Eye Report must be attached to referral copy of DSB-7103. Also attach copy of any other data relevant to consumer's situation**. Do not send a copy to the Register Clerk but instead send the DSB-1010.

DSB-7103 , Independent Living Services Program Assessment and Plan

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DSB-7103B ORIENTATION AND MOBILITY SERVICE PLAN [F-8]

PURPOSE:

This form will be used to document a plan of specialized services for ILS consumers referred to an Orientation and Mobility Specialist by the Case Manager (Social Worker for the Blind) or by another Resource Specialist.

PREPARED BY:

Orientation and Mobility Specialists will complete the Plan following their assessment and acceptance of consumers referred to them for specialized services.

DSB-7103B must be completed in a timely manner so that service delivery is initiated at the earliest possible time after referral but **no later than 90 calendar days after the referral is received in the DSB district office**.

INSTRUCTIONS:

SECTION I. Identifying Data

1. **Consumer's Name** - Enter client's full name.

2. **Consumer's Telephone Number** - Enter phone number, if available.

3. **Case Manager's Name/County** - Enter name and county of case manager (SWB).

4. **Referring Worker** - Enter name of referring worker, if different from case manager.

5. **Date Referral Received** - Enter date referral was received in district office.

SECTION II. Areas of Need for Specialized Services

Using data gathered during the needs assessment, indicate the consumer's area(s) of need. Also refer to assessment data documented on DSB-7103: ILS Assessment and Plan developed by the SWB. List services planned in order to meet these needs.

SECTION III. Service Delivery Objective(s)

In behavioral terms state how the consumer will attain the ILS goal listed on DSB-7103: ILS Assessment and Plan.

Examples:

A. Consumer will be able to travel as independently as possible in home and neighborhood by learning support cane skills.

B. Consumer will attain safe and independent travel skills by learning by learning self-protective arm positions, trailing, and orientation skills.

SECTION IV. Time Frame

Enter the beginning date and the projected completion date for each service delivery objective.

SECTION V. Statements and Signatures

These statements must be reviewed with the consumer or his/her parent/guardian. The consumer or parent/guardian must sign and date the Plan. The Orientation and Mobility Specialist must also sign and date the Plan.

DISTRIBUTION:

Original: Case Record
Copy: Case Manager
Referring Worker, if other than Case Manager

DSB-7103-B, Orientation and Mobility Service Plan

DSB-4043 MINI-CENTER MOBILITY REPORT [F-9]

INSTRUCTIONS:

Consumer's Name: Enter consumer's full name.

Consumer's Address: Enter complete address including the county.

Dates of Instruction: Enter dates of instruction in mini-center.

Topics Covered: Check as many boxes as appropriate and write in other topics as needed.

Additional Services: Check as many boxes as appropriate and write in requested information (length, style of cane, etc.)

Special Services Provided: Indicate any services not covered by services listed above.

Special Services and/or Devices Needed: Indicate any services and/or devices needed that the O&M Instructor was not able to provide within the scope of training in the Mini-Center. If the consumer needs in-depth individual training, this should be noted here as well as any special O&M devices.

O&M Specialist Signature: The Specialist providing training in the Mini Center should sign.

Date: Enter the date of the report which will likely be the last date the O&M Instructor provides instruction to the consumer in the mini-center setting. If the consumer needs additional instruction, the O&M Instructor will complete the DSB-7103B (the Orientation and Mobility Service Plan) and provide the instruction in the home and community setting.

DISTRIBUTION:

Original: O&M Specialist Record
Copy: Referral Source Record

DSB-4043, Mini-Center Mobility Report

DSB-7108 AGREEMENT FOR IN-HOME AIDE SERVICES: LEVEL I-HOME MANAGEMENT [F-10]

PURPOSE:

To establish a working understanding between the In-Home Aide Services recipient/family, the In-Home Aide and the Division of Services for the Blind. This Agreement will specify the In-Home Aide Services: Level I-Home Management to be provided and the number of hours per month they will be provided.

PREPARED BY:

The Social Worker for the Blind is responsible for preparing this Agreement in consultation with the consumer and In-Home Aide.

GENERAL INSTRUCTIONS:

1. The agreement will be completed before the beginning date of service as listed on DSB-7108.

2. A new Agreement may be negotiated at any time during the time period covered by the Agreement to accommodate necessary changes in tasks, hours, etc.

3. **If the consumer continues to be eligible for In-Home Aide Services: Level I Home Management at the time of his/her annual re-determination of eligibility, it is not necessary to do a new Agreement if there is no change. Note review date and state "No change" on the DSB-7108.**

4. Total number of hours per month cannot exceed 100 unless the Field Services Manager has provided written removal for additional hours. Letter of Approval must be attached to original Authorization with copy retained in case record. **The maximum amount paid cannot exceed $999 (including FICA-both employer and employer parts) in any quarter.**

5. Rate of pay is current State minimum wage. If the prevailing county wage for DSS In-Home Aide Services: Level I exceeds the State minimum wage, this higher rate may be authorized with the written approval of the Field Services Manager. Letter of approval must be attached to original Authorization with copy retained in case record.

6. The Agreement must be read or read to (in its entirety) both the consumer (or his/her family member/responsible person) and the In- Home Aide.

SPECIFIC INSTRUCTIONS:

1. **Consumer Data**: List the consumer's name, phone number and address.

2. **In-Home Aide Data**: List the worker's name, phone number, address.

3. **Tasks to be Performed by Aide**: Indicate by "X" the tasks Aide will be responsible for providing and write in how often they are to be performed.

4. **Specific Hours Worked/Day**: List the specific hours that are to be worked and the total number of hours each day. Refer to item 4 in

GENERAL INSTRUCTIONS:

5. **Specific Days Worked/Week**: Indicate the specific days that In-Home Aide will work for consumer and the number of days per week.

6. **Aide's beginning and Expected Ending Date for Services**: Indicate Aide's first day of work and, if known, indicate Aide's expected ending date for services.

7. **Hourly Rate of Pay**: List current State minimum wage or, if approved by Field Services Manager, the prevailing County rate. Refer to item 5 in General Instructions. Maximum Hours/Mo: Indicate the number of hours per month the Aide is authorized to work.

8. **Hours of training**: Indicate the number of hours of training the Aide will complete and/or the hours of training the Aide has already completed.

9. **Aide Statement**: Indicate the Aide's name in the first space and the consumer's name in the second space.

10. **Signature and Dates**: Signatures of the consumer (or family member/responsible person) and the Aide are required at the time the Agreement is completed. The date must be written below each signature.

11. **Changes in Agreement**: Indicate any changes to be made during the one year eligibility period by indicating the changes in a different color of ink in the body of the agreement and then both the Consumer and the In-Home Aide will initial with the date on print page 4 of this form.

DISTRIBUTION:

Original: Consumer's case record
Copy: Consumer, In-Home Aide

DSB-7108, Agreement for In-Home Aide Services: Level I- Home Management

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DSB-7219 APPLICATION FOR CONFERENCE [F-11]

PURPOSE:

To notify the Area Supervisor of Social Services and the Chief of the Independent Living Services Program in the DSB State Office of a consumer's dissatisfaction with the service program and to request a conference concerning his/her dissatisfaction.

PREPARED BY:

The Social Worker for the Blind will prepare the DSB-7219.

INSTRUCTIONS:

1. Enter consumer's name, address including city, state and county, and his/her telephone number on the appropriate lines.

2. Briefly describe the reason(s) for conference request.

3. Enter date and obtain the signature of the consumer.

DISTRIBUTION:

Original Copies (White): Chief, Independent Living Services in DSB State Office
Blue: DSB Area Supervisor of Social Services
Yellow: County Department of Social Services
Pink: Appellant

DSB-7219, Application for Conference

DSB-7309 TIME LOG FOR IN-HOME SERVICES: LEVEL I-HOME MANAGEMENT [F-12]

PURPOSE:

To provide daily documentation of days and time worked by In-Home Services Aide to bill for In-Home Aide Services: Level I - Home Management.

PREPARED BY:

The form is completed by the In-Home Aide for time entries while the Social Worker for the Blind is responsible for entering identifying data, total hours, hourly rate, and total amount payable.

INSTRUCTIONS:

1. Enter month, day, and year for beginning and ending dates of service during the report month.

2. In-Home Aides will list, by the respective day of the month, the time they began work, the time they ended work, and the total time worked.

3. On or after the Aide's last working day of the month, he/she will sign and date in the Certification section to verify that the hours listed were worked by him/her.

4. On or after the Aide's last working day of the month, the consumer will sign and date to certify that he/she received satisfactory services and that the hours reported are correct. If the consumer signs with a mark, the signature must be witnessed by someone other than the In-Home Services Aide.

5. For initial billing, enter in the upper-right corner:

a. authorization number
b. the letter "P" if the bill if for partial payment on the Authorization or the letter "F" for final payment.

6. For supplemental billing, enter in the upper-right corner:

a. the word "Supplemental"
b. Authorization number
c. the letter "P" if the bill is for partial payment on the Authorization or the letter "F" for final payment.

7. The Social Worker for the Blind will sign and date the form and enter his/her worker number and county. He/she will also complete the section at the bottom of form "Completed by DSB Staff" with total hours worked, hourly rate and the total amount payable to the In-Home Aide.

DISTRIBUTION:

Original: Program Benefits/Payment Section of DHHS Controller's Office

Mailing Address:
DSB Claims Processing Unit
2023 Mail Service Center
Raleigh, NC 27699-2023

Please call the Controller's Office at 919-715-9590 for the appropriate person to submit your authorizations for payment.

Currently authorizations are divided up as follows:

A-E

Plus: Nash Optical

Revolving Fund

F-M

Plus: Aids & Appliances

N-Z

Plus: Phillip Barton Visions

DSB-7309, Time Log In-Home Service: Level I-Home Management

DSB-7311 TRAINING RECORD FOR IN-HOME AIDE LEVEL I-HOME MANAGEMENT [F-13]

PURPOSE:

This form is used to record training sessions that In-Home Aides for Level I: Home Management are required to attend.

PREPARED BY:

The Social Worker for the Blind will complete DSB-7311.

INSTRUCTIONS:

1. Enter name of the In-Home Aide.

2. For each training session that Aide attends, record training date(s), the sponsoring agency or person, the number of hours or on-the job training, and briefly describe type of training.

3. Use lower section of form for additional notes or comments regarding the Aide's training record.

DISTRIBUTION:

Original: Social Worker for the Blind
Copy: Regional/District Office

DSB-7311, Training Record for In-Home Aide (Level I-Home Management)

DSB-7399 FORMS REQUEST [F-14]

PURPOSE:

To provide a list of frequently used forms that are available in the District Offices and to allow the Social Workers for the Blind and the Orientation and Mobility Specialists to order on this form.

PREPARED BY:

The Social Worker for the Blind and the Orientation and Mobility Specialist will complete the DSB-7399 when forms are needed.

INSTRUCTIONS:

1. Enter name of District Office Staff person who distributes forms under "To".

2. Enter the worker's name who is requesting the forms.

3. Enter the date of the request.

4. Enter the office address where the worker wants the forms to be mailed.

5. Beside each form needed, the worker should indicate the number requested under "Requested".

6. Beside each form that was requested, the District Office staff person should enter the number of the forms mailed under "Sent".

DISTRIBUTION:

Original: District Office Staff Person Who Distributes the Forms Copy: Worker's File

DSB-7399, Forms Request

DHHS-1000 AUTHORIZATION TO DISCLOSE HEALTH INFORMATION [F-15]

PURPOSE:

DHHS-1000 is used to protect individually identifying health information maintained by DSB. No DHHS agency shall disclose or be required to disclose, in individually identifiable format, information about an individual without that individual's explicit authorization, unless for specifically enumerated purposes such as emergency treatment, public health, law enforcement, audit/oversight purposes or unless state or federal law allows specific disclosures.

INSTRUCTIONS:

Client Name: Enter the first, maiden or middle initial, and the last name of the applicant/recipient of services.

Date of Birth: Enter the month, day and year of birth of the applicant/consumer.

Client Medical Record Number: Enter the medical record number of the applicant/consumer at the facility/provider of services where the health information originated.

Client or Personal Representative: The name of the applicant/consumer or his/her duly authorized representative should be entered. If a personal representative signs the authorization form, a description of such authority to act for applicant/consumer must also be documented on the form.

Name of Provider/Plan: The name of the entity owning the medical records should be entered on this line. This could be an eye care practitioner's office, a hospital, an insurance company, etc.

Recipient Name/Address Phone/Fax: Enter the name and other information relating to the entity that is to receive the health information.

For the Specific Purpose(s): Enter the specific reason the health information is needed (examples: to provide medical information so decisions can be made about services authorized/payment of invoices or to determine eligibility for services as a visually impaired person.

Specific Information to be Disclosed: Enter an explanation of what information is needed and why it is needed (example: an eye report from the 10-2-02 visit is needed to pay an outstanding invoice or determining eligibility for ILS.)

Expiration Date of Authorization: Enter the date the eligibility for the MEC Program expires or if not related to MEC, one year from date signed.

The applicant/consumer should either read the statements on the authorization or the interviewer should read them to him/her. If a copy of the authorization is requested, it should be supplied to the applicant/consumer. If the applicant/consumer or a personal representative is unable to sign his/her name, an "X" or other mark/symbol is acceptable instead of a signature as long as it is witnessed and documented, attesting to the validity of the signature.

If the applicant/consumer should desire to revoke the authorization, the back of the form should be completed. **Also, it is very important to indicate the date of the revocation and the signature of the staff person who witnessed the revocation at the bottom of page 1 of the DHHS-1000 (1-03); DSB (4-03). This would prevent someone from assuming that the authorization was good until the expiration date.**

DHHS-1000, Authorization to Disclose Health Information

DSB DRIVING STATUS FORM [F-16]

PURPOSE:

The Division of Services for the Blind is concerned about the safety of our consumers who employ In-Home Level I aides with whom they may occasionally ride to purchase groceries, etc. The Driving Record Status Form **must be completed by all potential employees of the consumer who may provide In-Home Level I Services. Also, if there are media reports or if the consumer has reason to suspect that a person he/she has already employed as an In-Home aide has received traffic citations for unsafe driving practices (such as DWI charges), then the consumer and SWB may request the provider to complete the Driving Record Status Form. If the aide refuses to complete this form which would allow a check with DMV records, this refusal may br grounds for the consumer to terminate the aide's employment.**

PREPARED BY:

The Social Worker for the Blind will assist the consumer and the consumer's potential or existing employee in completing the form.

INSTRUCTIONS:

Consent: Instruct the potential/current provider of In-Home Level I Services to read the form and check the box if consent is given to proceed with a driving record review. Potential/Current In-Home Aide Provider signs and dates the form.

Print Name: Enter the full name of the potential/current provider of In-Home Level I.

Home Address: Enter the correct home address that has been provided by the potential/current provider of In-Home Level I Services. Note: If the person has recently moved and has not changed his/her address with DMV, the address in the DMV system may be different. It may be necessary to show both addresses.

Driver's License Number: Enter the Driver License number on the form and verify that the person before the SWB is actually the person whose picture is on the Driver License.

Employment: Check the appropriate box to indicate if DSB employee, DSB driver, or DSB contractual teacher.

Employment Dates: Enter employment beginning and end date.

Signature: Instruct the potential/current provider of In-Home Level I Services to sign his/her complete name.

Date: Enter the date the Driving Record Status Form is signed.

DISTRIBUTION:

Original: DSB Personnel Officer
Copy: Consumer's case record

DSB Driving Record Status Form

DHHS CRIMINAL RECORD CHECK FOR DIRECT CARE EMPLOYMENT-TRANSMITTAL FORM [F-17]

PURPOSE:

The Division of Services for the Blind and the Department of Health and Human Resources are taking every precaution to ensure that our consumers are aware of and protected from persons who may have a criminal record when the consumer hires someone to work in his/her home through the In-Home Level I Service. Thus the DHHS Criminal Record Check for Direct Care Employment Transmittal Form and the DHHS Criminal Record Check for Direct Care Employment Consent Form must be completed for all potential In-Home Level I providers.

PREPARED BY:

The Social Worker for the Blind will assist the consumer and potential provider of In-Home Level I Services in the completion of this form.

INSTRUCTIONS:

SECTION I

DHHS Division/Institution: Leave blank. Personnel Officer will complete.

Phone Number: Leave blank.

Fax Number: Leave blank.

Requesting Official: Leave blank.

Position: Leave blank.

Applicant/Employee Name and Address: Enter the complete name of the person and address whom the consumer wants to employ as an In-Home Level I Aide.

Race: Enter the race of the person whom the consumer wants to employ.

Sex: Check either Male or Female for the sex of the consumer's potential employee.

DOB: Enter the date of birth or the consumer's potential employee.

Social Security Number: Enter the nine digit SSN of the consumer's potential employee.

Driver's License: State/Number: Enter the name of the state in which the license was issued and the number of the driver's license.

Height: Enter the height of the consumer's potential employee.

Weight: Enter the weight of the consumer's potential employee.

Eye Color: Enter the eye color of the consumer's potential employee.

Hair Color: Enter the hair color of the consumer's potential employee.

Position: Enter "In-Home Level I Provider" and indicate that it is a direct care position.

Residency Past 5 Years: Indicate if the potential employee of the consumer has resided outside of NC in the past five years.

SECTION II - Leave blank. Personnel Officer will complete.

DISTRIBUTION:

Original: DSB Personnel Office
Copy: Consumer's case record

DHHS Criminal Record Check for Direct Care Employment- Transmittal Form

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DHHS CRIMINAL RECORD CHECK FOR DIRECT CARE EMPLOYMENT-CONSENT FORM [F-18]

PURPOSE:

The Division of Services for the Blind and the Department of Human Resources are concerned about the safety and well-being of it's consumers who employ In-Home aides. The potential employee of the consumer **must** sign the release form to allow a criminal record check and receive a report free of serious past criminal activity before the consumer can hire the person as a provider of In-Home Level I: Home Management Services through DSB.

INSTRUCTIONS:

The Social Worker for the Blind and/or the consumer of In-Home Level I Services should instruct the potential employee of the consumer to carefully read the Release Statement on the Consent Form for the Criminal Record Check. The potential employee should then sign and date the form.

DISTRIBUTION:

Original: DSB Personnel Officer
Copy: Consumer's case record

CRIMINAL RECORD CHECKS OF EXISTING EMPLOYEES OF THE CONSUMER FOR IN-HOME LEVEL I: HOME MANAGEMENT SERVICES

If the consumer has an employee who is providing In-Home Level I Services and an incident of criminal activity is reported in the media or if the consumer suspects that the provider has become involved in criminal activity, the consumer and the Social Worker for the Blind may request that the provider of In-Home Level I Services give permission for a criminal record check at any time. If the provider refuses to give permission for the criminal record check, this refusal is grounds for dismissal of the provider by the consumer.

DHHS Criminal Record Check for Direct Care Employment- Consent Form

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PAYMENT VERIFICATION FORM [F-19]

PURPOSE

In-home Aides complete this form to receive payments electronically in a savings or checking account rather than by a paper check.

INSTRUCTIONS

1. The In-Home Aide enters their name, social security number, their bank, their routing number which is at the bottom of their check, and their checking or saving account number.
2. Attach a voided check and mail this document to the following address:

   DHHS Controller's Office
   2019 Mail Service Center
   Raleigh, NC 27699-2019
   Telephone: 919-715-8985
   Fax: 919-715-4829
3. The link for this form can be accessed from the DSB Forms Home Page http://info.dhhs.state.nc.us/olm/forms/forms.aspx?dc=dsb
4. The In-Home Aide can receive notification of their electronic deposit by email or fax. No paper checks will be received by the aide. If the aide does not have an email address or fax then they can receive notification of deposit through a DSB established email address. The Director's administrative assistant is the portal for these email requests when an electronic deposit has been made in an aide's name. The Administrative assistant can notify by telephone or regular mail of the aide's electronic deposit. The email address is dsbdeposit2004@yahoo.com and the

administrative assistant can be reached at 919-733-9822 or by contacting the agency's toll-free number at 1-866-222-1546.

Distribution: Copy to In-home Aide

Payment Verification Form