**Support Service Provider Program Application for Services**

The Division of Services for the Blind and Visually Impaired (DSBVI)

250 N 1950 W Ste. B

Salt Lake City, UT 84116

Date:

**Please tell us about yourself,**

Name:

Date of Birth:

Street Address:

City, State, ZIP Code:

Phone Number:

Is this: VP, Voice, Text, or TTY?

E-Mail Address:

Do you use a Service Animal? Yes or No?

Do you use Hearing Aids, Yes or No?

Do you use a cochlear Implant, Yes or No?

\* If you use a cochlear implant, when did you get your implant?

What is your preferred style of communication? Speech, Sign Language, or a combination of both?

Please write “Yes” by each communication style that you use:

American Sign Language (ASL)

Signed English

Finger Spelling

Spoken English

Other:

Do you consider yourself more visual or tactile?

Please write “Yes” by each of the following technology that you use:

Smart Phone

Computer

Texting Phone

Fax

Other:

**Please describe your eyesight.**

Eye Condition:

Eye Physician:

Date Last Seen:

(Please Submit Report)

How do you prefer to receive mail? regular print, large print, braille, or other?

**Please describe your hearing.**

Severity of hearing loss:

Audiologist/ Otologist:

Date Last Seen:

(Please Submit Report)

Additional Requests: Ex. Female SSP/ Weekend Apts. / etc.

Required Reports: Vision, Hearing, HKNC Report showing applicant registered as Deafblind.

Please write yes to all of the following that apply to you:

I am not being served by any district educational system and do not have an IEP.

I am not receiving services from the Division of Services for People with Disabilities (DSPD).

I am a current resident of Utah or am working towards residency.

I have had the DBSSP Program explained to me by the Deafblind Specialist and agree to comply with the regulations as written in the Deafblind Support Service Provider Guidelines.

Before signing this document, verify that the content in the application is complete and correct. Electronic signature is valid.

Signature:

Date: