ATTENTION:

Please complete and sign the following forms. These are fillable PDF forms that can be filled out on the computer and returned to me via email. However, the Authorization to Obtain/Release Health Information needs to be signed by hand. My mailing address, email address and fax number are listed below. Choose whatever mode is convenient for you.

Please complete and return these 3 documents to me (Stephanie Bissonette):

1. Application for Children Services, including the VABVI Authorization to Obtain/Release Health Information
2. Copy of the One Plan, IEP or 504 Plan
3. Eye report. (If you do not have a copy, then VABVI will request one for you.)

Please keep the following attached forms:

- The Vermont Client Assistance Project
- Notice of Privacy Practices
- Direct Service Fees
- Cancellation Policy
- Role and Function of Service Providers

Please Note:

- The most current eye report must be provided before the child can be seen by any of our teachers.
- Any other pertinent information from your file regarding this child will be greatly appreciated; especially an IEP, 504 Plan or an IFSP/One Plan.
- In order for our staff to get paid, VABVI services must be added to the service pages of One Plans, IEP's and 504 Plans.

Thank you for the referral and I hope you found this process convenient!

Sincerely,

Stephanie Bissonette
Children's Services Supervisor

VT Association for the Blind & Visually Impaired
60 Kimball Avenue, South Burlington, VT 05403
Email: sbissonette@vabvi.org
Phone: 800-639-5861 x 225
Fax: 802-863-1481

Vermont Association for the Blind and Visually Impaired

Application for Children Services

Demographic Information

Child's Name:	
Primary Phone:	
Parent 1 name:	
E-mail:	
Phone:	Work Phone:
Additional Phone:	
Mailing Address:	
Physical Address (if different):	
Directions:	
Parent 2 name:	
E-mail:	
Phone:	Work Phone:
Additional Phone:	
Mailing Address:	
Physical Address (if different):	
Child lives with:	
Date of Birth:	
Age:	Gender: Female ☐ Male ☐
SSN:	
Medicaid:	
Referral Date:	
School Year:	
Grade:	
County:	
Emergency Contact:	
Emergency Phone:	
Referred by:	
How did you hear about VABVI services?:	
Referral Reason:	
Deaf/Blind? ☐ yes ☐ no	I-Team? ☐ yes ☐ no

Vermont Association for the Blind and Visually Impaired

Application for Children Services

SCHOOL

Elementary • Middle • High School • Early Intervention

School/EI/ECSE Name:	
Phone:	Fax:
Mailing Address:	
Primary Teacher:	
E-Mail:	
Case Manager:	
Phone:	Fax:
Mailing Address:	
E-Mail:	
Choose one: ☐ 504 Plan ☐ IEP ☐ One Plan/IFSP ☐ IEP/Braille ☐ Not Applicable	
504/Special Ed. Coordinator:	
Phone:	Fax:
School District:	
District Mailing Address:	

Doctor/Medical Information

Cause of Vision Loss:	
Ophthalmologist:	
Mailing Address:	
Phone:	Fax:
Physician:	
Mailing Address:	
Phone:	Fax:
Disabling Conditions:	

Vermont Association for the Blind and Visually Impaired

Authorization to Obtain/Release Health Information
Children Services

Name: _____ **D.O.B:** _____

Address: _____

Phone: _____

Parent's Email: _____

I authorize the mutual exchange of information between the Vermont Association for the Blind and Visually Impaired and the following Ophthalmologist/Optometrist/Physician/Other. (Please list below:)

Ophthalmologist/Optometrist:

1. _____ **Phone:** _____

_____ **Fax:** _____

_____

School District:

2. _____ **Phone:** _____

_____ **Fax:** _____

_____

Other:

3. _____ **Phone:** _____

_____ **Fax:** _____

_____

TYPE OF DISCLOSURE:	**PURPOSE FOR DISCLOSURE:**
X -Ophthalmologic Reports	**X** -Evaluation for Rehabilitation Services
X -Medical Reports	**X** -Low Vision Clinic Evaluation
X -VABVI Client Records	☐ At Client Request for Client Use
	☐ Continuing Care
☐ OTHER (explain)	☐ Insurance
	☐ Legal

Please sign on next page.

Clients Name: _____

I understand that:

- All information will be kept confidential; however, by signing this authorization I give permission for information to be shared (if applicable) with the VT Division f/t Blind; the Low Vision Optometrist; VT Department of Libraries; Telephone Exemption Services; Volunteer Services; New England Consortium on Deafblindness; the VT Agency of Education; the American Printing House for the Blind's Quota Fund and/or Learn, Earn and Prosper (LEAP).
- I understand by not signing this form, I will not be referred for the services mentioned above, and will receive VABVI service only.
- Once healthcare information is disclosed, VABVI may re-disclose it in some situations. Privacy laws may no longer protect the information.
- A photocopy of this authorization will be accepted with the same authority as the original, and is valid for six (6) years.
- I am aware of my right to an appeal through CAP if the provision of service is not satisfactory.
- I have the right to revoke this authorization at any time, and must present my written revocation to VABVI. If I revoke my authorization, it will not affect any actions already taken by VABVI based upon this authorization.

X _____ _____ _____

Authorized Signature **Relationship** **Date**

Vermont Association for the Blind & Visually Impaired

Acknowledgement as to the Use and Disclosure of Health Information

Please note:

Federal Law requires that we provide the people we serve with our Privacy Practices (enclosed), which explain how your health information will be used or shared with others.

Your signature simply verifies that you received the information, not that you necessarily have read it or agree with it.

I have been provided a "Notice of Privacy Practices" that explains the uses and disclosures that the Vermont Association for the Blind and Visually Impaired will make with respect to my health information.

_____

Name of Client or Legal Representative

_____

Signature of Client or Legal Representative

_____

Date

CAP

The Vermont Client Assistance Project

CAP is a private non-profit organization serving Vermonters with disabilities. Do you need free information or assistance regarding:

- **Available services?**
- **Resolution of disagreements with the program?**
- **Pursuing your legal rights?**

CAP will assist you if you feel that you are being denied services, are concerned about eligibility, feel that things are taking too long, or have questions about the agency or agencies you are working with. CAP will help in cases where you cannot resolve differences with your teacher or counselor.

Further information is available from Vermont Association for the Blind and Visually Impaired in braille, large print, or tape, or you may contact CAP.

Call 800-747-5022 (Grand Isle, Franklin, Orleans, Essex, Caledonia, Lamoille, Washington, or Chittenden Counties).

Or

Call 800-769-7459 (Addison, Orange, Rutland, Windsor, Windham, or Bennington Counties).

All phones are TTY equipped and you may call collect.

Vermont Association for the Blind and Visually Impaired

NOTICE OF PRIVACY PRACTICES

***This information is available in braille or audio cassette at your request. Call 1-800-639-5861 x 231.**

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Protecting Your Personal and Health Information

The Vermont Association for the Blind and Visually Impaired (VABVI) is committed to protecting the privacy of your personal information. We are required by applicable federal and state laws to maintain the privacy of your personal and health information. This notice explains our privacy practices, our legal duties, and your rights concerning your personal and health information. Personal and health information (referred to in this notice as "personal information") means any information that is identifiable to you as your personal information, including information regarding your health care and/or treatment; identifiable factors including your name, age, address, income or other financial information. We will follow the privacy practices that are described in this notice while it is in effect.

Why do we collect your personal information? We collect personal information from you for a number of reasons, including helping us determine the appropriate products and services to offer, to pay claims, to provide case management services, and to provide quality improvement services.

How do we collect your personal information? We collect your personal information through you and your health care providers. For example, we receive personal information from you in person, in a telephone interview, on your insurance, from health care and other providers, and through insurance transactions such as referrals for service and submission of claims for reimbursement of covered benefits.

How do we protect your personal information?

We protect your personal information by:

- Treating all of your personal information that we collect as confidential;
- Stating confidentiality policies and practices in our employee handbooks as well as disciplinary measures for privacy violations;
- Restricting access to your personal information only to employees who need to know in order to provide services to you;
- Only disclosing your personal information that is necessary for a service company to perform its function on our behalf, and the company agrees to protect and maintain the confidentiality of your personal information; and
- Maintaining physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your personal information.

How do we use and disclose your personal information? We won't disclose your personal information unless we are allowed or required by law to make the disclosure, or if you (or your authorized representative) give us permission. Uses and disclosures, other than those listed below, require your authorization. If there are other legal requirements under applicable state laws that further restrict our use or disclosure of your personal information, we'll comply with those legal requirements as well. Following are the types of disclosure that we may make as allowed or required by law:

- **Treatment:** Personal information for our activities or for the treatment activities of a health care provider. Treatment activities include disclosing your personal information to a provider in order for that provider to treat you.
- **Payment and Billing:** For our payment and billing activities, including payment and billing for claims from insurance companies, or other providers of service to you
- **Health Care Operations:** For our internal operations.
- **Business Associates:** Third party "business associates" who perform certain activities for us such as our auditors or those who maintain our computer systems. We require these business associates to afford your personal information the same protection afforded by us.
- **To You or Your Authorized Representative:** Once you provide us with an authorization, you may revoke it in writing at any time. Your revocation won't affect any use or disclosure permitted by your authorization while it was in effect. In certain situations when disclosure of your information could be harmful to you or another person, we may limit the information available to you, or use an alternative means of meeting your request.
- **To Your Parents, if you are a Minor:** Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of the state where the treatment is provided, and will make any disclosure consistent with such laws.
- **Your Family and Friends:** If you are unable to consent to the disclosure of your personal information, such as in a medical emergency, we may disclose your personal information to a family member or friend to the extent necessary to help with your health care or with payment for your health care. We'll only do so if we determine that the disclosure is in your best interest.
- **Marketing:** To contact you with information about our products and services that may be of interest to you. We do not share or sell our mailing lists to other organizations.
- **Public Health and Safety:** If we believe disclosure is necessary to avert a serious and imminent threat to your health or safety or the health and safety of others. We may disclose your personal information to appropriate authorities if

we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or other crimes.

- **Required by Law:** We must disclose your personal information when we are required to do so by law.
- **Process and Proceedings:** In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Law Enforcement:** We may disclose limited information to law enforcement officials.
- **Military and National Security:** We may disclose to military authorities the personal information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials personal information required for lawful intelligence, counterintelligence, and other national security activities.

What rights do you have as an individual regarding use and disclosure of your personal information? You have the right to request all of the following:

- **Access to Your Personal Information:** To review and receive a copy of your personal information. We may charge you a nominal fee for providing you with copies of your personal information. This right does not include the right to obtain copies of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding: and protected health information that is subject to other state or federal laws that prohibit us to release such information. We may also limit your access to your personal information if we determine that providing the information could possibly harm you or another person. If we limit access based upon the belief that it could harm you or another person, you have the right to request a review of that decision.
- **Amendment:** To request that we amend your personal information. Your request must be in writing, and it must identify the information that you think is incorrect and explain why the information should be amended. We may decline your request for certain reasons, including if you ask us to change information that we didn't create. If we decline your request to amend your records, we'll provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you have authorized, of the amendment and to include the changes in any future disclosures of that information.
- **Accounting of Disclosures:** To receive a report of instances in which we or our business associates disclosed your personal information for purposes other than for treatment, billing/payment, health care procedures, and certain other activities. You are entitled to such an accounting for the 6 years prior to your request, though not for disclosures made prior to April 14, 2004. We'll provide you with the date on which we made a disclosure, the name of the person or entity to which we disclosed your personal information, a description of the

personal information we disclosed, the reason for the disclosure, and other applicable information. If you request this list more than once in a 12-month period, we may charge you a reasonable fee for creating and sending these additional reports.

- **Restriction Requests**: That we place additional restrictions on our use or disclosure of your personal information for treatment, payment, health procedures or to persons you identify. We may be unable to agree to your requested restrictions. If we do, we'll abide by our agreement (except in an emergency).
- **Confidential Communication:** That we communicate with you in confidence about your personal information by alternative means or to an alternative location or address. If you advise us that disclosure of all or any part of your personal information could endanger you, we will comply with any reasonable request provided you specify an alternative means of communication.
- **Electronic Notice:** If you receive this notice on our Web site or by electronic mail (email), you're also entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

When is this notice effective? April 14, 2004 and will remain until we revise it.

What if this notice of privacy practices changes? We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. For your convenience, a copy of our current notice of our privacy practices is always available on our Web site at VABVI.ORG, and you may request a copy at any time by contacting us at the number below.

How can you reach us? If you want additional information regarding our Privacy Practices, or if you believe we have violated any of your rights listed in this notice, please contact our privacy officer:

Dan Norris, Supervisor of Adult Services/Deafblind Consultant
1-877-350-8838; VABVI, 13 Overlook Drive, Suite 1, Berlin, VT 05641

Stephanie Bissonette, Supervisor of Children's Services
1-800-639-5861, ext. 225; VABVI, 60 Kimball Ave., South Burlington, VT 05403

Steve Pouliot, Executive Director
1-800-639-5861, ext. 233; VABVI, 60 Kimball Ave., South Burlington, VT 05403

If you have a complaint, you may also submit a written complaint to the U. S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon your request. Your privacy is one of our greatest concerns and there's never any penalty to you if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

VERMONT ASSOCIATION FOR THE BLIND AND VISUALLY IMPAIRED

HELPING ACHIEVE INDEPENDENCE IN A VISUAL WORLD SINCE 1926

VABVI Cancellation Policy

Dear School Personnel, Parents/Guardians,

I am writing you to provide agency policies and procedures regarding canceled or missed appointments.

Agency policy requires our teachers to count any appointment canceled by the school or parent with less than 24 hours notice as billed time. If you need to cancel an appointment, please notify the teacher's secretary prior to 24 hours of the scheduled appointment.

If our teachers need to cancel an appointment, they will contact you with as much advance notice as possible. If they cancel an appointment, they will make up that time by the end of the year.

During the school year, if your address or phone number changes, please let us know so that there is no lost time due to communication failure.

Thank you in advance for your efforts in this matter. We look forward to a positive and productive school year.

Respectfully,

Stephanie Bissonette

Stephanie Bissonette
Supervisor of Children's Services

60 Kimball Avenue
S. Burlington, VT 05403
(802) 863-1358
(FAX) 863-1481

13 Overlook Drive, Ste. 1
Berlin, VT 05641
(802) 505-4006
(FAX) 505-4039

80 West Street, Ste. 202
Rutland, VT 05701
(802) 775-6452
(FAX) 755-4669

130 Austine Drive, Ste. 280
Brattleboro, VT 05301
(802) 254-8761
(FAX) 254-4802

Burl (800) 639-5861
Berlin (877) 350-8838
Rutland (877) 350-8839
Bratt (877) 350-8840

www.vabvi.org