State of Illinois
Department of Human Services - Division of Rehabilitation Services

OLDER INDIVIDUALS WHO ARE BLIND - OIB
CUSTOMER TRACKING REPORT

Provider: _____ Report Date: _____

First Name: _____

Last Name: _____

Address: _____

City, State, ZIP _____ ___ _____

County: _____

Phone: _____

Email: _____

Specify: _____

Date of Birth: _____

SSN (Last 4 Digits): _____

Gender:
- ◯ Individual self identifies as male
- ◯ Individual self identifies as female
- ◯ Individual who did not self-identify gender

Race/Ethnicity:
- ☐ American Indian or Alaska Native
- ☐ Asian ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White ☐ Hispanic/Latino
- ☐ Individual did not self- identify race
- ☐ Two or more races

Visual Impairment: ◯ Totally Blind ◯ Legally Blind ◯ Severe Visual Impairment

Major Cause: ◯ Cataracts ◯ Diabetic Retinopathy ◯ Glaucoma ◯ Macular Degeneration ◯ Other _____

Other Impairment: ◯ Cognitive or Intellectual Impairment ◯ Mobility Impairment ◯ Communication Impairment ◯ Mental Health Impairments ◯ Hearing Impairment ◯ Other Impairment _____

Type of Residence: ◯ Private Residence (house/apartment) ◯ Assisted Living Facility ◯ Homeless ◯ Nursing Home/Long term care facility ◯ Senior Living/Retirement Community

Referral Source: ◯ Eye Care Provider (ophthalmologist, optometrist) ◯ Physician/Medical Provider ◯ State VR Agency ◯ Veterans Administration ◯ Government/public or private social ◯ Assisted Living Facility ◯ Nursing Home/Long term care facility ◯ Senior Center ◯ Faith-based Organization ◯ Independent Living Center ◯ Service agency not listed elsewhere ◯ Family or Friend ◯ Self ◯ Other _____

Services Provided Beginning FY: ☐☐

- ☐ Vision Screening/Exam/Low Vision Eval
- ☐ Advocacy Training and Support
- ☐ Information, Referral, Community
- ☐ Communication Skills
- ☐ Orientation and Mobility Training
- ☐ Assistive Technology Devices/Aids
- ☐ Counseling (peer, indiv., group)
- ☐ Supportive Services (reader, etc.)
- ☐ Assistive Technology Services
- ☐ Daily Living Skills
- ☐ Other Independent Living Service _____

Open Date:		Interviewer:	
Close Date:		Closed By:	
Reason:			