**Application for Ohio Stateside SSP Services**

**1. Name:**

**2. Home Address:**

**3. Email Address:**

**4. Voice Phone:**

**5. VP/TTY Phone:**

**6. Cell Phone:**

**7. What is the best way to contact you?**

**8. Date of Birth:**

**9. Hispanic/Latino/Spanish origin: Yes, No**

**10. Circle One: White, Black, Asian, Other**

**11. Circle One: Male, Female, Other**

**12. Circle one: Married, Divorced, Single, Widow**

**13. What is the cause of your deafblindness? (Circle all that apply.)**

**From Birth Birthing Complications Accident**

**Childhood Disease Usher Syndrome Age-Related**

**Other Disease or Injury Unknown**

**14. Describe Hearing Loss. Circle One:  Mild, Moderate, Severe**

**15. Describe Vision Loss:**

**16. Your preferred mode of communication (Circle One)**

**Primarily Gesture Tactile Primarily Manual**

**Print On Palm Primarily Oral Assistive Devices**

**Primarily TC Read/Write Braille Read/Write Notes**

**17. Do you move independently using a white cane, guide dog, or any other mobility aid?**

**18. Describe your living situation. Circle one:**

**Alone With Spouse/Family Friend/Roommate Other**

**19. On a scale of 1 to 5, with 1 meaning not independent and 5 meaning totally independent, how independent do you feel on a day-to-day basis accomplishing tasks and errands?**

**1 I do not feel independent—Always, I rely on others.**

**2 I feel a little bit independent – Often, I rely on others.**

**3 Half the time I feel independent and rely on others.**

**4 I feel mostly independent – Sometimes, I rely on others.**

**5 I feel completely independent – I do not rely on others.**

**20. If you rely on others, who helps you? (Circle all that apply.)**

 **Roommate Family Friends SSP PCA Other**

**21. What things affect your independence? (i.e., transportation)**

**22. How will you use SSP services? Circle all that apply. Write in other uses.**

**Shopping (grocery, clothes, household items)**

**Reading (mail, email, labels)**

**Errands (pharmacy, banking)**

**Appointments (doctor, personal care)**

**Communication Assistance and making appointments Exercising**

**Paying bills**

**Attending social/cultureal events**

**Voting**

**Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**23. List all serious allergies or diagnoses that your SSP must be aware:**

**24. In case of emergency, please list two contacts (name, Relationship, Contact info – voice/text/vp)**

**25. How did you learn about CSH SSP services?**

**26. We are trying to show the need for SSP services. Will you share your experiences with SSP services over the next year with our partners at Capital University? Circle One: Yes No**

**Proof of combined vision and hearing loss is required. Please submit proof with application. (Example of proof of vision and hearing loss: OOD referral, doctor, HKNC referral, DODD)**