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| DATA COLLECTION SHEET FOR A PATRON WHO IS BLIND OR VISUALLY IMPAIRED  Questions on this form are explicitly used to obtain data to be used for the purpose of obtaining grants, requesting donations, developing programs and services, and fundraising. Personal information gathered in this form that specifically identifies an individual is confidential information that will not be disclosed or released to the public. | **Logo says "Central Illinois Center for the Blind and Visually Impaired." White cane with red tip to right of text.** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| patron Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last Name | | | |  | | | | | | | | | | | | | | | | | | | | | | First | | | |  | | | | | | | | | | | M.I. | | |  | Date | | |  | | |
| Street Address | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Apartment/Unit # | | | | | | | |  | |
| City |  | | | | | | | | | | | | | | | | | | State | | | | |  | | | | Zip | | |  | | | | | | County | | | | |  | | | | | | | | |
| Phone |  | | | | | | | | | | | | | | | | | | | | | | | | | E-mail Address | | | | |  | | | | | | | | | | | | | | | | | | | |
| Date of Birth  mm/dd/yyyy | | | | | |  | | | | | | | | | | Emergency  Contact: | | | | |  | | | | | | | | | | | | | | | | | Emergency  Contact  Phone Number | | | | | | | |  | | | | |
| Emergency contact  Relationship to you | | | | | | | | |  | | | | | | | | | | | | | In the event of a medical emergency, which hospital do you prefer? | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| Gender | | Male | | | | | | | Female | | | | | Prefer not to say | | | | | | | | | | | Age as of today: | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Ethnicity/Race | | | | | | | American Indian or Alaska Native | | | | | | | | | | Asian | | | | | | Black or African American | | | | | | | | Hispanic/Latino | | | | Native Hawaiian or Other Pacific Islander | | | | | | | | | | | | | | | White |
| Type of blindness or visual impairment:  (what was medical diagnosis if known) | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | How long have you been blind or visually impaired? | | | | | | | | | | | Since birth | | | | | | | At the age of: | | | |
| Is it alright if the Center lists your birthday and/or wedding anniversary in the monthly newsletter? (month/day only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES  NO | | | |
| Education/financial/general information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Highest level of education | | | | Less than 12 years  High School  Associate  Bachelor  Master’s  Doctorate  GED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employment Status | | | | | Employed  Unemployed  Retired | | | | | | | | | | | | | | | | | | | | | | Where employed? | | | | | |  | | | | | | | | | | | | | | | | | |
| Job Title | | |  | | | | | | | | | | | | | | | | | | | | Address  Of employer | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
| Type of income or assistance applicable to you | | | | | | | | | | | | | Supplemental Security Income  Social Security Retirement  Social Security Disability  Salary | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you live with a sighted person? | | | | | | | | | | | | YES  NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How close do you live to a relative? | | | | | | | | | | | Within 1-5 miles  within 6-15 miles  within 16-30 miles  over 30 miles away | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How close do you live to the Center? | | | | | | | | | | | Within 1-5 miles  within 6-15 miles  within 16-30 miles  over 30 miles away | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you use public transportation? | | | | | | | | | | | | | | | YES  NO | | | | | | | | | | Would you use the Center’s transportation service? | | | | | | | | | | | | | | | | | | YES  NO  MAYBE | | | | | | | |
| I get at least 30 minutes of exercise. | | | | | | | | | | | | | | | | | | | | Daily  4-5 times a week  2-3 times a week  Once a week  Never | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I feel my personal safety is at risk. | | | | | | | | | | | | | | | | | | | | Strongly Disagree  Disagree  Neutral  Agree  Strongly Agree | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I would like to receive the monthly newsletter in the following format. | | | | | | | | | | | | | | | | | | | | Large print  Braille  Thumb drive  mp3 (sent in email)  Email (using Mailchimp) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I am a U.S. Veteran | | | | | | | | | | YES  NO | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The Central Illinois Center for the Blind and Visually Impaired is here to serve you. Please list services, programs, or concerns that are important to you so that the Center can better serve your needs. List programs that you are currently using. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How long have you been coming to the Center, including the time  when the Center was previously known as the Peoriarea Blind People’s Center? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | \_\_\_ YEARS \_\_\_ MONTHS | | | | | | | | | | | | | | |
| **MEDICAL/NUTRITIONAL INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I have a physical disability that requires the use of a walker or wheelchair | | | | | | | | | | | | YES  NO | | | | | | | | | | | | | | | | | Food Allergies | | | | |  | | | | | | | | | | | | | | | | |
| Special Dietary Needs | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | Medications | | | | |  | | | | | | | | | | | | | | | | |
| This form was filled out by: | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | Title | | | | |  | | | | | | | | | | | | | | | | |

When completing this form electronically, please click on “Save As” and save the file under the person’s last name and first initial.

Additional notes:

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Revision 3 – 11/2019