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# UNITED STATES DEPARTMENT OF EDUCATION

## OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES

## REHABILITATION SERVICES ADMINISTRATION

Washington D.C. 20202

FISCAL YEAR

ANNUAL REPORT

## INDEPENDENT LIVING SERVICES FOR

## OLDER INDIVIDUALS WHO ARE BLIND

**GRANTEE** _____

**GRANT NO.** _____

**Title VII Chapter 2, of the Rehabilitation Act, as amended**
**Section 752(l)(2)(A) of the Rehabilitation Act, as amended**

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## PART I: FUNDING SOURCES FOR EXPENDITURES AND ENCUMBRANCES

| | | | |
|---|---|---|---|
| **Title VII-Chapter 2 federal grant award for reported fiscal year** | | | $ |
| **Title VII-Chapter 2 carryover from previous year** | | | $ |
| **A.** | **Funding Sources for Expenditures and encumbrances in Reported FY** | | **Expended or encumbered** |
| A1. | Title VII-Chapter 2 | | $ |
| A2. | Total other federal (a)+(b)+(c)+(d)+(e) | | $ |
| | (a) Title VII-Chapter 1-Part B | $ | |
| | (b) SSA reimbursement | $ | |
| | (c) Title XX - Social Security Act | $ | |
| | (d) Older Americans Act | $ | |
| | (e) Other | $ | |
| A3. | State (excluding in-kind) | | $ |
| A4. | Third party | | $ |
| A5. | In-kind | | $ |
| A6. | **TOTAL** MATCHING FUNDS (A3+A4+A5) | | $ |
| A7. | **TOTAL** ALL FUNDS EXPENDED (A1+A2+A6) | | $ |
| **B.** | **Total expenditures and encumbrances allocated to administrative, support staff, and general overhead costs** | | $ |
| **C.** | **Total expenditures and encumbrances for direct program services** (Line A7 minus Line B) | | $ |

## PART II: STAFFING

FTE (full time equivalent) is based upon a 40-hour workweek or 2080 hours per year.

| **A.** | **Full-time Equivalent (FTE) Program Staff** | **Administrative & Support** | **Direct Service** | **TOTAL** |
|---|---|---|---|---|
| A1. | FTE State Agency | a. | b. | c. |
| A2. | FTE Contractors | a. | b. | c. |
| A3. | **TOTAL** FTE (A1 + A2) | a. | b. | c. |
| **B.** | **Employed or advanced in employment** | | **No. employed** | **FTE** |
| B1. | Employees with Disabilities (include blind and visually impaired not 55 or older) | | a. | b. |
| B2. | Employees with Blindness Age 55 and Older | | a. | b. |
| B3. | Employees who are Racial/Ethnic Minorities | | a. | b. |
| B4. | Employees who are Women | | a. | b. |
| B5. | Employees Age 55 and Older (not blind and visually impaired) | | a. | b. |

| C. | Volunteers | |
|---|---|---|
| C1. | FTE program volunteers (no. of volunteer hours ÷ 2080) | |

## PART III: DATA ON INDIVIDUALS SERVED

Provide data in each of the categories below related to the number of individuals for whom one or more services were provided during the reported fiscal year.

| A. | INDIVIDUALS SERVED | |
|---|---|---|
| A1. | Number of individuals who began receiving services in the previous FY and continued to receive services in the reported FY | |
| A2. | Number of individuals who began receiving services in the reported FY | |
| A3. | **TOTAL** individuals served during the reported fiscal year (A1+ A2) | |
| **B.** | **AGE** | |
| B1. | 55-59 | |
| B2. | 60-64 | |
| B3. | 65-69 | |
| B4. | 70-74 | |
| B5. | 75-79 | |
| B6. | 80-84 | |
| B7. | 85-89 | |
| B8. | 90-94 | |
| B9. | 95-99 | |
| B10. | 100 & over | |
| B11. | **TOTAL** (Add B1 through B10, must agree with A3) | |
| **C.** | **GENDER** | |
| C1. | Female | |
| C2. | Male | |
| C3. | **TOTAL** (Add C1 + C2, must agree with A3) | |
| **D.** | **RACE/ETHNICITY** | |
| D1. | Hispanic/Latino of any race or Hispanic/ Latino only | |
| D2. | American Indian or Alaska Native, not Hispanic/Latino | |
| D3. | Asian, not Hispanic/Latino | |
| D4. | Black or African American, not Hispanic/Latino | |
| D5. | Native Hawaiian or Other Pacific Islander, not Hispanic/Latino | |
| D6. | White, not Hispanic/Latino | |
| D7. | Two or more races, not Hispanic/Latino | |
| D8. | Race and ethnicity unknown, not Hispanic/Latino (only if consumer refuses to identify) | |
| D9. | **TOTAL** (Add D1 through D8, must agree with A3) | |
| **E.** | **DEGREE OF VISUAL IMPAIRMENT** | |
| E1. | Totally Blind (LP only or NLP) | |
| E2. | Legally Blind (excluding totally blind) | |
| E3. | Severe Visual Impairment | |

| | | |
|---|---|---|
| E4. | **TOTAL** (Add E1 through E3, must agree with A3) | |
| **F.** | **MAJOR CAUSE OF VISUAL IMPAIRMENT** | |
| F1. | Macular Degeneration | |
| F2. | Diabetic Retinopathy | |
| F3. | Glaucoma | |
| F4. | Cataracts | |
| F5. | Other | |
| F6. | **TOTAL** (Add F1 through F5, must agree with A3) | |
| **G.** | **OTHER AGE-RELATED IMPAIRMENTS** | |
| G1. | Hearing Impairment | |
| G2. | Diabetes | |
| G3. | Cardiovascular Disease and Strokes | |
| G4. | Cancer | |
| G5. | Bone, Muscle, Skin, Joint, and Movement Disorders | |
| G6. | Alzheimer's Disease/Cognitive Impairment | |
| G7. | Depression/Mood Disorder | |
| G8. | Other Major Geriatric Concerns | |
| **H.** | **TYPE OF LIVING ARRANGEMENT** | |
| H1. | Lives alone | |
| H2. | Lives with others (family, spouse, caretaker, etc.) | |
| H3. | **TOTAL** (Add H1 + H2, must agree with A3) | |
| **I.** | **TYPE OF RESIDENCE** | |
| I1. | Private residence (house or apartment) | |
| I2. | Senior Living/Retirement Community | |
| I3. | Assisted Living Facility | |
| I4. | Nursing Home/Long-term Care facility | |
| I5. | **TOTAL** (Add I1 through I4, must agree with A3) | |
| **J.** | **SOURCE OF REFERRAL** | |
| J1. | Eye care provider (ophthalmologist, optometrist) | |
| J2. | Physician/medical provider | |
| J3. | State VR agency | |
| J4. | Government or Social Service Agency | |
| J5. | Senior Program | |
| J6. | Faith-based organization | |
| J7. | Independent Living center | |
| J8. | Family member or friend | |
| J9. | Self-referral | |
| J10. | Enter the number of individuals served referred by the Veterans Administration | |
| J11. | Other | |
| J12. | **TOTAL** (Add J1 through J10, must agree with A3) | |

## PART IV: TYPES OF SERVICES PROVIDED AND RESOURCES ALLOCATED

Provide data related to the number of older individuals who are blind receiving each type of service and resources committed to each type of service.

| | | | | |
|---|---|---|---|---|
| **A.** | **Clinical/functional vision assessments and services** | | | |
| A1. | a. Total Cost from VII-2 funds<br>b. Total Cost from Other funds | $<br>$ | | **# Persons Served** |
| A2. | Vision screening / vision examination / low vision evaluation | | | |
| A3. | Surgical or therapeutic treatment to prevent, correct, or modify disabling eye conditions | | | |
| **B.** | **Assistive technology devices and services** | | | |
| B1. | a. Total Cost from VII-2 funds<br>b. Total Cost from Other funds | $<br>$ | | **# Persons Served** |
| B2. | Provision of assistive technology devices and aids | | | |
| B3. | Provision of assistive technology services | | | |
| **C.** | **Independent living and adjustment training and services** | | | |
| C1. | a. Total Cost from VII-2 funds<br>b. Total Cost from Other funds | $<br>$ | | **# Persons Served** |
| C2. | Independent living and adjustment skills training | | | |
| C3. | Orientation and Mobility training | | | |
| C4. | Communication skills | | | |
| C5. | Daily living skills | | | |
| C6. | Supportive services (reader services, transportation, personal attendant services, support service providers, interpreters, etc) | | | |
| C7. | Advocacy training and support networks | | | |
| C8. | Counseling (peer, individual and group) | | | |
| C9. | Information, referral and community integration | | | |
| C10. | Other IL services | | | |
| **D.** | **Community Awareness Activities/ Information and Referral Services** | | | |
| D1. | a. Total Cost from VII-2 funds<br>b. Total Cost from other funds | $<br>$ | **# Events/ Activities** | **# Persons Served** |
| D2. | Information and Referral (optional) | | | |
| D3. | Community Awareness: Events/Activities | | a. | b. |

## PART V: COMPARISON OF PRIOR YEAR ACTIVITIES TO CURRENT REPORTED YEAR

| | | Prior FY | Reported FY | Change (+ / -) |
|---|---|---|---|---|
| A1. | Program Cost (all sources) | a. | b. | c. |
| A2. | No. Individuals Served | a. | b. | c. |
| A3. | No. of Minority Individuals Served | a. | b. | c. |
| A4. | No. of Community Awareness Activities | a. | b. | c. |
| A5. | No. of Collaborating agencies and Organizations (other than sub-grantees) | a. | b. | c. |
| A6. | No. of Sub-grantees | a. | b. | c. |

## PART VI: PROGRAM OUTCOMES/PERFORMANCE MEASURES

Provide the following data for each of the performance measures below. This will assist RSA in reporting results and outcomes related to the program.

| VI. | PROGRAM OUTCOMES/PERFORMANCE MEASURES | No. of Persons |
|---|---|---|
| A1. | Number of individuals who received orientation and mobility (O & M) services (refer to Part IV C3). | |
| A2. | Of those receiving orientation and mobility (O & M) services, the number of individuals who experienced functional gains or maintained their ability to travel safely and independently in their residence and/or community environment as a result of services. | |
| A3. | Number of individuals for whom functional gains have not yet been determined at the close of the reporting period. | |
| B1 | Number of individuals who received services or training in alternative non-visual or low vision techniques (refer to Part IV C2). | |
| B2. | Number of individuals that experienced functional gains or successfully restored or maintained their functional ability to engage in their customary life activities as a result of services or training in alternative non-visual or low vision techniques. | |
| B3. | Number of individuals for whom functional gains have not yet been determined at the close of the reporting period. | |
| C1. | Number of individuals receiving AT (assistive technology) services and training (refer to Part IV B2). | |
| C2. | Number of individuals receiving AT (assistive technology) services and training who regained or improved functional abilities that were previously lost or diminished as a result of vision loss. | |
| C3. | Number of individuals for whom functional gains have not yet been determined at the close of the reporting period. | |
| D1. | Number of individuals served who reported feeling that they are in greater control and are more confident in their ability to maintain their | |

| | | |
|---|---|---|
| | current living situation as a result of services they received. | |
| D2. | Number of individuals served who reported feeling that they have less control and confidence in their ability to maintain their current living situation as a result of services they received. | |
| D3. | Number of individuals served who reported no change in their feelings of control and confidence in their ability to maintain their current living situation as a result of services they received. | |
| D4. | Number of individuals served who experienced changes in lifestyle for reasons unrelated to vision loss | |

**PART VII: NARRATIVE**

A. Briefly describe the agency's method of implementation for the Title VII-Chapter 2 program (i.e. in-house, through sub-grantees/contractors, or a combination) incorporating outreach efforts to reach underserved and/or unserved populations. Please list all sub-grantees/contractors.

B. Briefly describe any activities designed to expand or improve services including collaborative activities or community awareness; and efforts to incorporate new methods and approaches developed by the program into the State Plan for Independent Living (SPIL) under Section 704.

C. Briefly summarize results from any of the most recent evaluations or satisfaction surveys conducted for your program and attach a copy of applicable reports.

D. Briefly describe the impact of the Title VII-Chapter 2 program, citing examples from individual cases (without identifying information) in which services contributed significantly to increasing independence and quality of life for the individual(s).

E. Finally, note any problematic areas or concerns related to implementing the Title VII-Chapter 2 program in your state.

## PART VIII: SIGNATURE

Please sign and print the name, title and telephone number of the IL-OIB Program Director below.

I certify that the data herein reported are statistically accurate to the best of my knowledge.

| Name (Printed) | Title | Telephone Number |
|---|---|---|

| Name (Signature) | Date |
|---|---|