N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
INDEPENDENT LIVING SERVICES

ORIENTATION AND MOBILITY SERVICE PLAN

I. IDENTIFYING DATA

Client's Name: ______________________ Telephone Number: ______________

Case Manager's Name/ County: ______________________________

Referring Worker (if different from above): ______________________

Date Referral Received: ______________

II. AREAS OF NEED FOR SPECIALIZED SERVICES (check appropriate boxes and describe services planned)

- ☐ Orientation & Mobility Evaluation ______________________
- ☐ Counseling ______________________
  - ☐ Client ______________________
  - ☐ Parent/ Guardian ______________________
- ☐ Consultation ______________________
- ☐ Sighted Guide ______________________
- ☐ Protective Skills ______________________
- ☐ Orientation Training ______________________
- ☐ Independent Mobility ______________________
- ☐ Long Cane Travel ______________________
- ☐ Support Cane Travel ______________________
- ☐ Low Vision Evaluation ______________________
- ☐ Low Vision Aids ______________________
- ☐ Instructions in Distance Aids ______________________
- ☐ Travel Accommodation ______________________
- ☐ Public Transportation ______________________
- ☐ Electronic Travel Aids ______________________
- ☐ Other ______________________

III. SERVICE OBJECTIVE

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IV. TIME FRAME-

______________ to ______________

(beginning date) (ending date)

V. STATEMENT AND SIGNATURES

I, the undersigned have been informed of my rights and responsibilities. I have participated in the development of this Plan and it has been read to me. I agree to these services.

______________________________	______________________________
Orientation and Mobility Specialist	**Client (Parent/ Guardian)**
______________________________	______________________________
Date	**Date**