Montana Association for the Blind

1302 24th St. W.
PMB 134
Billings, MT 59102
406-442-9411

2025 Summer Orientation Program for the Blind/Partially Sighted

Dear Applicant,

We are accepting applications up to May 31, Call 406-442-9411.

Enclosed is an application for the Montana Association for the Blind's Summer Orientation Program for the Blind and Partially Sighted (SOP). It is in three parts:

Part 1 – Application for Enrollment to be completed by the applicant and returned by Tuesday, April 15, 2025, for best consideration. This can be turned in before Parts 2 and 3 are submitted. Applications received after that will be considered as well depending on space.

Part 2 – A current Physical Examination Report to be completed by your physician, and returned before Tuesday, May 6, 2025.

Part 3 – A current Visual Examination Report from your eye doctor. A visual exam must be completed within the past 12 months and submitted before Tuesday, May 6, 2025.

Your name and address must be complete on each form. All blanks must be completed on each form.

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PLEASE TYPE OR PRINT CLEARLY

Applications received by Tuesday, April 15, 2025, will be given first consideration, so it is to your advantage to complete and return the entire application as soon as possible. You will be notified by mail by mid-May 2025 of the Committee's decision on your application.

The program is designed to help people with vision impairment acquire the skills and attitudes that will enable them to remain independent and self-reliant. Individuals who are currently driving or require an assisted living setting for medical purposes do not qualify for the program.

Students are responsible for their routine medical care. A parttime medical aid is available to assist with medication if needed. If an emergency arises or any sterile treatment is needed, we must call an ambulance to transport the student to the hospital.
Students must bring the medication they will need to the program.

This year's program will be at the Ursuline Center campus in Great Falls, Montana. Classes are scheduled to be held from Monday, June 16 through Friday, July 11, 2025. There is no charge for accepted students. The MAB will provide room and board and necessary equipment for student training. The student must provide food supplements and medical supplies. Students who own adaptive equipment on which they would like to receive training are welcome to bring such items to the program.

All students must take Activities of Daily Living (ADL), group discussion, and Orientation and Mobility (O & M). Students then may choose from other classes available classes: low vision aids, Braille, computers, keyboarding, cooking, workforce skills, crafts, exercise, smart technology, sewing, and woodworking.

PLEASE TYPE OR PRINT CLEARLY

Students accepted in this program will take classes determined by their interests, Montana Blind and Low Vision Services input, and the SOP

committee. Class schedules will be presented on the first day of the program—no class changes will be allowed during the first week.

Punctual attendance of all classes that students are enrolled in is required for successful completion of this program. We may add or subtract classes depending on student needs.

Please return Part 1 by the April 15, 2025 deadline, even if the medical and visual forms are not immediately available. Please return the medical and visual forms as soon as possible.

We would appreciate having the application information typed or clearly printed if possible.

If you have any questions, you may contact:

Montana Association for the Blind
1302 24th St. W.
PMB 134
Billings, MT 59102
Phone: (406) 442-9411

Please share this letter with your physicians.

Sincerely,
Summer Orientation Program Committee

Montana Association for the Blind

1302 24th St. W.
PMB 134
Billings, MT 59102
406-442-9411

2025 SUMMER ORIENTATION PROGRAM for the Blind and Partially Sighted Sponsored by the Montana Association for the Blind, Inc.

Mail completed application to:
MAB
1302 24th St. W.
PMB 134
Billings, MT 59102
Or submit to: mabadmin@mabsop.org

Part 1 – Personal Information

PLEASE TYPE OR PRINT CLEARLY

Name: _____

Street: _____

City: _____ Zip: _____

Phone: _____ Email: _____

Date of Birth: _____ Age: ____

PLEASE TYPE OR PRINT CLEARLY

Are you a Veteran: Yes ____ No __

Do you have Medicare: Yes ____ No __
Medicare Number: _____
Do you have Part B: Yes ____ No ____

Medicaid Number (if applicable): _____

Other Health Insurance and Number:
_____

Primary Insurance Carrier: _____

Sex: Male _____ Female ____

List your primary medical doctor with their phone number:

_____

_____

Do you have any allergies: Yes__ No _____ If Yes, please list them: _____
_____
___

PLEASE TYPE OR PRINT CLEARLY

In case of emergency, notify:

Name: _____

Relationship: _____

Phone: _____ Cell Phone: _____

What are your work experiences?

_____

What are your hobbies and interests?

_____

Have you attended a previous session of the MAB's Summer Orientation Program?

Yes _____ When _____ No _____

Your vision loss was caused by: _____

_____

_____

Date of Onset: _____

PLEASE TYPE OR PRINT CLEARLY

How would you describe your vision?

_____
_____

_____
___

Do you have any disabilities and/or medical conditions other than your visual impairment?

Yes _____ No _____

If yes, please describe: _____
_____
_____

Do you have hearing loss? Yes _____ No ____

Do you use hearing aids? Yes _____ No ___

Are you a client of the State of Montana Blind and Low Vision Services?

Yes _____ No ___

Name of Counselor: _____

PLEASE TYPE OR PRINT CLEARLY

Can they be contacted: Yes ____ No ____

Have you been issued a white cane?

Yes _____ No ____

If yes, have you received training in the use of the white cane?

Yes _____ No _____

Do you use any aids to walk other than for your visual impairment?

Yes _____ No _____

Do you require supplementary oxygen?

Yes _____ No _____

Do you require a breathing apparatus at night for sleeping?

Yes _____ No _____

PLEASE TYPE OR PRINT CLEARLY

Are you fit enough to walk 4 blocks without physical assistance from another person?

_____

PLEASE TYPE OR PRINT CLEARLY

Do you rely upon any other physical apparatuses such as walkers, braces, etc.?

Yes _____ No _____

If yes, please explain what you use.

_____

_____

_____

Are you a Diabetic?

Yes _____ No _____

If yes is your Diabetes controlled with Insulin injections or oral preparation or by both or by diet only?

Insulin Type _____ Oral ____ Both ____ Diet only ___

Are you currently driving a vehicle?

Yes _____ No _____

If yes, explain the reason. _____

_____

_____

Client Signature: _____Date: _____

The enclosed medical forms (physical and eye), completed and signed by your physicians, should be returned by May 6, 2025.