

ED(RSA)-7-0B Form
OMB No. 1820-0608
Expiration Date:

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 (OIB) Program

GRANTEE _____
GRANT NO. _____

Title VII Chapter 2, of the Rehabilitation Act, as amended by Title IV of the Workforce Innovation and Opportunity Act (WIOA) Sections 751(b) and 752(h)(2)(A) of the Rehabilitation Act, as amended by the Workforce Innovation and Opportunity Act (WIOA)

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PART I: FUNDING SOURCES AND EXPENDITURES IN SUPPORT OF THE OIB PROGRAM

A. Funding Sources and Amounts in Support of the OIB Program for the Reported Federal Fiscal Year (FFY)

- | | |
|---|----------|
| 1. Title VII-Chapter 2 Federal grant award for reported FFY | \$ _____ |
| 2. Title VII-Chapter 2 carryover from previous FFY | \$ _____ |
| 3. Total Title VII-Chapter 2 Funds (A1 + A2) | \$ _____ |
| 4. Title VII-Chapter 1, Part B Funds | \$ _____ |
| 5. Other Federal funds available for expenditure in the reported FFY | \$ _____ |
| 6. TOTAL FEDERAL FUNDS (A3 + A4 + A5) | \$ _____ |
| 7. State funds (excluding in-kind contributions) | \$ _____ |
| 8. In-kind contributions | \$ _____ |
| 9. Other non-Federal funds | \$ _____ |
| 10. TOTAL NON-FEDERAL FUNDS (A7 + A8 + A9) | \$ _____ |
| 11. TOTAL OF ALL FUNDS AVAILABLE FOR EXPENDITURE IN THE REPORTED FFY (A6 + A7 + A9) | \$ _____ |

B. OIB Program Expenditures in Reported FFY

- | | |
|---|----------|
| 1. Funds expended for administrative costs in the reported FFY | |
| a. Administrative expenditures from (1) Title VII-Chapter 2 OIB Federal grant award funds and (2) non-Federal sources used in meeting the match requirement | \$ _____ |
| b. Administrative expenditures from all other allowable sources as identified in Part IA above | \$ _____ |
| c. Total administrative expenditures (Sum of 1A and 1B) | \$ _____ |
| 2. Funds expended for direct program services | |

during the reported FFY

- a. Direct service expenditures from (1) Title VII-Chapter 2 OIB Federal grant award and (2) funds from non-Federal sources used in meeting the match requirement \$ _____
 - b. Direct service expenditures from all other allowable sources as identified in Part IA above \$ _____
 - c. Total direct service expenditures (Sum of 2a and 2b) \$ _____
-
3. Total funds expended for the program during the reported FFY (B1c + B2c) \$ _____

PART II: PROGRAM STAFFING

A. Full-time Equivalent (FTE) Program Staff

FTE (full time equivalent) is based on the number of hours per week considered full time for the position.

Type of staff	Administrative & Support (a)	Direct Service(b)	TOTAL (c)
1. FTE State Agency	(a)	(b)	(c)
2. FTE through contract/subgrant	(a)	(b)	(c)
3. TOTAL FTE (A1 + A2)	(a)	(b)	(c)

B. Employees with Disabilities

Employees with Disabilities (agency and contract/subgrant staff)	Number of Employees
1. Employees with Disabilities other than blindness or severe visual impairments	
2. Employees with Blindness or Severe Visual Impairments who are Age 55 and Older	
3. Employees with Blindness or Severe Visual Impairments who are under Age 55	
4. TOTAL EMPLOYEES with Disabilities (B1 + B2 + B3)	

PART III: DATA ON INDIVIDUALS SERVED

Provide data in each of the categories below on the number of individuals for whom one or more services were provided (program participants) during the reported FFY.

A. Individuals Served

1. Number of individuals who began receiving services in the previous FFY and continued to receive services in the reported FFY _____
2. Number of individuals who began receiving services in the reported FFY _____
3. TOTAL individuals served during the reported FFY (Sum of A1 + A2)

B. Age at Application

1. 55-64 _____
2. 65-74 _____
3. 75-84 _____
4. 85 & over _____
5. TOTAL - Sum of B1 + B2 + B3 + B4, total must agree with A3

C. Gender

1. Individual self-identifies as female _____
2. Individual self-identifies as male _____
3. Individuals who did not self-identify gender _____
4. TOTAL - Sum of C1 + C2 + C3, total must agree with A3

D. Race

1. American Indian or Alaska Native _____
2. Asian _____
3. Black or African-American _____
4. Native Hawaiian or Other Pacific Islander _____
5. White _____
6. Individual Did Not Self-Identify Race _____

7. Two or More Races _____

8. TOTAL - Sum of D1 + D2 + D3 + D4 + D5 + D6 + D7, total must agree with A3

E. Ethnicity

1. Hispanic or Latino _____

F. Degree of Visual Impairment

1. Totally Blind (Light perception only or no light perception) _____

2. Legally Blind (excluding totally blind) _____

3. Severe Visual Impairment _____

4. TOTAL - Sum of F1 + F2 + F3, total must agree with A3

G. Major Cause of Visual Impairment

1. Macular Degeneration _____

2. Diabetic Retinopathy _____

3. Glaucoma _____

4. Cataracts _____

5. Other Cause of Visual Impairment _____

6. TOTAL - Sum of G1 + G2 + G3 + G4 + G5, total must agree with A3

H. Other Age-Related Impairments

1. Hearing Impairment _____

2. Mobility Impairment _____

3. Communication Impairment _____

4. Cognitive or Intellectual Impairment _____

5. Mental Health Impairments _____

6. TOTAL - Sum of H1 + H2 + H3 + H4 + H5, total must agree with A3

I. Type of Residence

- 1. Private Residence (house or apartment) _____
- 2. Senior Independent Living Facility _____
- 3. Assisted Living Facility _____
- 4. Nursing Home/Long-term Care Facility _____
- 5. Homeless _____
- 6. TOTAL - Sum of I1 + I2 + I3 + I4 + I5, total must agree with A3

J. Source of Referral

- 1. Eye care provider (ophthalmologist, optometrist) _____
- 2. Physician/medical provider _____
- 3. State VR agency _____
- 4. Government/Public or Private Social Service agency not listed elsewhere _____
- 5. Veterans Administration _____
- 6. Senior Program _____
- 7. Assisted Living Facility _____
- 8. Nursing Home/Long-term Care Facility _____
- 9. Independent Living Center _____
- 10. Family Member or Friend _____
- 11. Self-referral _____
- 12. Other Sources _____
- 13. TOTAL - Sum of J1 through J12, total must agree with A3

PART IV: TYPES OF SERVICES PROVIDED AND FUNDS EXPENDED

Provide data related to the number of older individuals who are blind receiving each type of service and funds expended for each type of service.

A. Clinical/functional vision assessments and services

1. Total expenditures from all sources of program funding \$ _____
2. Persons Served - Vision screening/vision examination/low vision evaluation _____
3. Persons Served - Surgical or therapeutic treatments to prevent, correct, or modify disabling eye conditions _____

B. Assistive Technology devices and services

1. Total expenditures from all sources of program funding \$ _____
2. Total unduplicated count of persons served - Provision of assistive technology devices and/or services _____

C. Independent living and adjustment training services

1. Total expenditures from all sources of program funding \$ _____
2. Total unduplicated count of persons receiving independent living and adjustment training services _____
3. Number of persons receiving the following services:
 - a. Orientation and mobility training _____
 - b. Communication skills training _____
 - c. Daily living skills training _____
 - d. Advocacy training _____
 - e. Adjustment counseling and/or peer support services (individual or group) _____

f. Information and referral services _____

g. Other independent living services _____

D. Supportive services

1. Total expenditures from all sources of program funding \$ _____

2. Total unduplicated count of persons served - Supportive services (reader services, transportation, personal attendant services, support service providers, interpreters, etc.) _____

E. Community Awareness Activities and Information and Referral

1. Total expenditure from all sources of program funding _____

F. TOTAL DIRECT EXPENDITURES - Sum of A1 + B1 + C1 + D1 + E1, total must agree with the direct service expenditures reported in Part 1, B2 _____

PART V: PROGRAM PERFORMANCE MEASURES AND OUTCOME DATA

Program Measures

Objective: To restore, improve, or maintain the independence of older individuals whose functional capabilities have been lost or diminished as a result of vision loss or blindness.

A. Assistive Technology Devices and Services

Measure A: The percentage of individuals receiving assistive technology devices and services who demonstrated improvement in one or more functional capabilities during the reported FFY consistent with the objectives for receiving such devices and services.

B. Independent Living and Adjustment Training Services

Measure B: The percentage of individuals receiving one or more independent living and adjustment training services who demonstrated improvement in functional capabilities during the reported FFY.

C. Independence in the home and community

Measure C1: The percentage of individuals completing a plan of services who reported feeling that they are more confident in their ability to maintain their current living situation.

Measure C2: The percentage of individuals completing a plan of services who reported an increased ability to engage in their customary daily life activities in the home and community.

D. Efficiency Measure (To be calculated by RSA MIS from data reported in PARTS I and III)

Objective: To provide cost effective supports and services to increase the independence of older individuals who are blind so that they may remain in the community and to prevent or delay the need for an increasing level of care, particularly for those individuals who are at risk of entering institutions.

Measure: The average annual cost per individual served through the program during the reported FFY.

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

PROGRAM PERFORMANCE DATA	Number of Persons	Percent of Persons
A. Assistive Technology Devices and Services		
A1. Enter the unduplicated number of individuals receiving assistive technology devices and services for whom change in functional capabilities was assessed, during the reported FFY (Denominator).		
A2. Enter the number of individuals receiving assistive technology devices and services who demonstrated improvement in one or more functional capabilities, during the reported FFY. (Numerator) Note: An individual who maintained but did not improve their capabilities may be reported here if the individual's goal was to prevent further decline in their capabilities.		
A3. The percentage of individuals receiving assistive technology devices and services who demonstrated improvement in one or more functional capabilities during the reported FFY consistent with the objectives for receiving such devices and services. (A2 divided by A1)	N/A	computed
B. Independent Living and Adjustment Training Services		
B1. Enter the unduplicated number of individuals receiving independent living and adjustment training services for whom change in functional capabilities was assessed during the reported FFY (Denominator).		
B2. Enter the unduplicated number of individuals receiving independent living and adjustment training services who demonstrated improvement in one or more functional capabilities. (Numerator) Note: An individual who maintained but did not improve their capabilities may be reported here if the individual's goal was to prevent further decline in their capabilities.		
B3. The percentage of individuals receiving one or more independent living and adjustment training services who demonstrated improvement in functional capabilities during the reported FFY.		computed
C. Independence in the Home and Community		

PROGRAM PERFORMANCE DATA	Number of Persons	Percent of Persons
C1. Enter the total number of individuals completing a plan of services during the reported FFY (Denominator).		
C2. Enter the number of individuals completing a plan of services during the reported FFY that reported an increased ability to engage in their customary daily life activities in the home and community (Numerator).		
C3. The percentage of individuals completing a plan of services who reported an increased ability to engage in their customary daily life activities in the home and community.		computed
C4. Enter the number of individuals completing a plan of services who reported feeling that they are more confident in their ability to maintain their current living situation as a result of services they received (Numerator).		
C5. The percentage of individuals completing a plan of services who reported feeling that they are more confident in their ability to maintain their current living situation.		computed
D. Efficiency Measure (To be calculated by RSA from data reported in PARTS I and III)		
D1. Total funds expended for direct program services during the reported FFY (as reported in PART I B2)	computed	
D2. Number of individuals receiving services during the reported FFY (as reported in PART III A3)	computed	
D3. The average annual cost per individual served through the program during the reported FFY.		computed

PART VI: TRAINING AND TECHNICAL ASSISTANCE NEEDS

Enter a brief description of training and technical assistance needs that you may have to assist in the implementation and improvement of the performance of your OIB program in your state.

Part VII: Narrative

- A. Briefly describe the agency's method of implementation for the OIB program (i.e. service delivery provided in-house, through sub-grantees/contractors, or a combination) incorporating outreach efforts to reach underserved and/or unserved populations. List all sub-grantees/contractors.

- B. Briefly summarize results from your recent evaluations or satisfaction surveys conducted for your program.

- C. Briefly describe the impact of the OIB 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).

- D. Briefly describe the community awareness/outreach efforts and information and referral activities conducted with Title VII-Chapter 2 funds and other funds and the outcome of those activities.

- E. Briefly describe capacity-building activities, including collaboration with other agencies and organizations (other than

with sub-grantees) and the outcome of these activities on the program.

PART VIII: SIGNATURE

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

Email

Date

Name (Signature)

Note: The report must be signed by a certifying official who is authorized to legally bind the non-Federal entity. By signing the report electronically, the grantee's certifying official certifies the following statement: "By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal award. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise." (2 C.F.R. § 200.415 and U.S. Code, Title 18, Section 1001).