Orientation and Mobility (O&M)

* = required field

I. Service Capacity

A. Identify which of the qualification categories applies to your provision of O&M services:
Individual Provider:* _____
Agency:* _____

B. Describe your regional service capacity throughout the State. Specify any areas that you do not provide O&M services:*

_____

C. Describe your capacity to provide translation for consumers when needed. *

Language	# Administrative Staff (if applicable)	# Certified Orientation and Mobility Specialists (COMS)

If you have no translation capacity, describe your procedure for serving consumers who have limited English-speaking ability.*

☐ N/A

_____

II. General Policies and Procedures

A. Describe your policy for notifying the ASAP about circumstances encountered that affect completion of authorized services (such as no answer at the door, weather conditions prevent training outside the home setting, etc.).*

_____

B. Describe how you confirm that O&M services are only provided to consumers who are not eligible for O& M through the Massachusetts Commission for the Blind. *

_____

III. Service Components

A. Describe what is included in your O& M assessment of an individual's needs, including orientation and mobility in both the home and community setting. *

_____

B. Describe how you provide individualized training and education in both the home and community setting.*

_____

C. Describe how you provide environmental evaluations.*

_____

D. Describe how you provide caregiver/direct care staff training on sensitivity to blindness/low vision.*

_____

E. Describe how you provide information and resources on community living for individuals with vision impairment or legal blindness.*

_____

IV. Staff Qualifications

A. Describe how you ensure that staff providing O&M are a Certified Orientation and Mobility Specialist (COMS) and have a master's degree in special education with a specialty in orientation and mobility or have a bachelor's degree with a Certificate in orientation and mobility from an ACVREP (Academy for Certification of Vision * Rehabilitation and Education Professionals) certified university program.

_____

Attach a COMS Certificate for each of your staff.*
Attachment Name: _____

V. Training

A. For Agencies employing COMS, describe your orientation. *
☐ N/A

_____

VI. Supervision

A. For Agencies employing COMS, describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors. *
☐ N/A

_____

VII. Proposed Rate Structure for Orientation and Mobility (O&M) *

_____

Provider employee who completed this form*

Name: _____ Date: _____