

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED
CHILDREN'S SERVICES APPLICATION

NOTICE: THIS FORM MAY BE SUBMITTED BY A PERSON WHO IS BLIND OR HAS SERIOUSLY IMPAIRED VISION, OR BY AN INDIVIDUAL OR AGENCY ON BEHALF OF A BLIND PERSON. PLEASE RETURN PROMPTLY IN THE PRE-ADDRESSED ENVELOPE PROVIDED.

Name of Child _____ Date of Birth _____

Child's Social Security Number _____

Parent/Guardian _____

Address _____

Phone () - _____ Work Phone () - _____

SCHOOL AND AGENCY INVOLVEMENT

Name and Address of Current School _____ Current Grade _____

Name and Address of agency(ies) with which your child is involved _____

Reason: _____

Cause of Visual Impairment _____ Age of onset _____

Can the child read small print? Yes No

Can the child read large print? Yes No

Does the child know Braille? Yes No

Can the child see colors? Yes No

Can the child type? Yes No

Does the child use a computer at school or at home? Yes No

Does the child use eyeglasses? Yes No

Can the child travel by him/herself? Yes No

Does the child have any other disabilities? Yes No

If yes, what conditions does she/he have? _____

I AM APPLYING FOR SERVICES FOR MY CHILD FROM THE NEW YORK STATE COMMISSION FOR THE BLIND AND VISUALLY HANDICAPPED AND AGREE TO COOPERATE IN OBTAINING INFORMATION TO DETERMINE HIS/HER ELIGIBILITY FOR SERVICES

SERVICES REQUESTED: _____

I HAVE THE FOLLOWING MEDICAL INSURANCE:

- MEDICAID PRIVATE INSURANCE NO INSURANCE

PARENT OR GUARDIAN'S SIGNATURE: _____

DATE: _____

IF APPLICATION IS SUBMITTED BY OTHER INDIVIDUAL OR AGENCY, FILL IN BELOW AND HAVE PARENT OR GUARDIAN SIGN ABOVE:

NAME/AGENCY: _____

ADDRESS: _____

SIGNATURE: _____

TITLE/RELATIONSHIP: _____

PHONE NUMBER: () _____