* Fax to Charnora Simon → 718-935-9463

OCFS-4599 (Rev. 12/2017)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REPORT OF LEGAL BLINDNESS / REQUEST FOR INFORMATION

NYS COMMISSION FOR THE BLIND

Please complete this information in full in order to avoid delay in registration of the patient and/or receipt of information requested.

PART A

REPORT OF LEGAL BLINDNESS: (Complete this part to report legal blindness)

PATIENT INFORMATION

NAME (Last):	(First):	MI	Sex	Birth Date: / /	Social Security Number:

STREET ADDRESS:			TELEPHONE NO: ( ) -
CITY:	STATE: NY	ZIP CODE:	COUNTY OR NYC BOROUGH:

EXAMINER

PLEASE CHECK THE APPROPRIATE CONDITION AND CAUSE: (Optometrist not required to indicate cause)

CONDITION	CAUSE
1. ☐ Blindness, both eyes, no light perception	1. ☐ Cataracts
2. ☐ Blindness, better eye, with best correction not more than 20/200	2. ☐ Glaucoma
3. ☐ Blindness, better eye, with visual field limitation less than 20 degrees	3. ☐ All other diseases:
4. ☐ Functions at the definition of legal blindness Due to a vision condition such as cortical visual impairment, standard acuity testing is impossible or unreliable and, in my medical opinion, the functional vision meets the definition of legal blindness.	4. ☐ Congenital condition
	5. ☐ Accident, poisoning, exposure, or injury
	6. ☐ Unspecified cause
5. ☐ Patient was registered as blind, is now **not blind**. *(Please check cause # 7)*	7. ☐ Improved Vision
6. ☐ This person is employed and is expected to become legally blind within the year.	

VISION DIAGNOSIS:

EXAMINER NAME:	PROFESSION OF EXAMINER: ☐ Physician ☐ Optometrist	EXAM DATE: / /

STREET ADDRESS:

CITY:	STATE:	ZIP CODE:	TELEPHONE NO.: ( ) -

EXAMINER SIGNATURE:
X

FOR INDIVIDUALS UNDER 18, THE NAME AND ADDRESS OF THE PARENT/GUARDIAN IS REQUIRED:

PARENT/GUARDIAN:	LAST NAME:	FIRST NAME:	
STREET ADDRESS:			
TELEPHONE NO.	( ) -	CITY:	STATE / ZIP CODE:

SUBMITTER (IF DIFFERENT FROM ABOVE)

SUBMITTER'S NAME:	LAST NAME:	FIRST NAME:	
STREET ADDRESS:			
TELEPHONE NO.:	( ) -	CITY:	STATE / ZIP CODE:

PART B

REQUEST FOR INFORMATION: (Complete this section if the individual is seeking information from NYSCB)

- ☐ How I can perform household tasks
- ☐ How NYSCB can assist me in preparing for a job
- ☐ How NYSCB can assist me in keeping my current job
- ☐ How NYSCB can assist in providing services to the above named visually impaired child
- ☐ Other services (specify):

Contact Person:	Phone No. ( ) -