

LDSS-2353 (4/15)

**EYE EXAMINATION CLEARANCE
BLIND APPLICANTS FOR
MEDICAL ASSISTANCE**

INSTRUCTIONS

1. Use for blind applicants for Medical Assistance.
2. Prepare in TRIPLICATE.
3. Forward first two parts to: New York State Commission for the Blind (NYSCB)
52 Washington Avenue, 2nd Floor. South Building
Suite 201
Rensselaer, New York 12144
4. The original will be returned after clearance to file in case file.

APPLICANT'S NAME (Last, First, M.I.)		MAIDEN NAME	COMM. REGISTRATION NO. (If known)
PRESENT ADDRESS		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH
PREVIOUS ADDRESS		IF IN INSTITUTION (Name and Address)	
NAME AND ADDRESS OF SUBMITTER		CASE NUMBER	DATE OF CLEARANCE

FOR COMMISSION USE ONLY

- CLASSIFIED BLIND AS OF
- CLASSIFIED NOT BLIND AS OF

MOST RECENT EYE EXAM REPORT SUBMITTED TO CBVH FOR ABOVE CLASSIFICATION WAS

- NO MANDATORY REPORT EVER RECEIVED BY CBVH FOR CLASSIFICATION

Please have an eye report Form LDSS-3377 completed.
Request the examiner to send directly to the Commission address above.
The examiner may be either an ophthalmologist or an optometrist.

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