NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

COMMISSION FOR THE BLIND

APPLICATION FOR SERVICE

NOTICE: This form may be submitted by a person who is blind or visually impaired, or by an individual or agency on behalf of that person

- If you have been mailed this form, please return it in the pre-addressed envelope provided.
- If you are filling this form out online, please fill out the form and save it as a WORD or PDF document to your desktop. Then mail or email the form to the District Office which is located closest to you. (Office and email addresses are listed on the back of this form).

APPLICANT INFORMATION				
First (Full):	Middle initial:	Last:		Social security number: - -
Street address (Apt. #):				Date of birth: / /
City:	State: **NY**	Zip code:	County:	Area code/ Phone number: ( ) -
If No phone, is there a number where applicant or parent/guardian can be reached? ☐ No ☐ Yes If Yes, please indicate: ( ) -			Email (of applicant or parent/guardian):	
Has applicant previously received services from the New York State Commission for the Blind (NYSCB)? ☐ No ☐ Yes If Yes, please provide applicant's NYSCB Eye Registration Number:				

SERVICES NEEDED BY APPLICANT: (Check all that apply.)

☐ Counseling and guidance
☐ Training in performing household tasks
☐ Assistance in preparing for and/or finding a job
☐ Assistance in maintaining current job
☐ Assistance in obtaining services for the above-named visually impaired child
☐ Other services

FOR APPLICANTS UNDER THE AGE OF 21 (Please complete the following):

Cause of visual impairment:

Age at onset _____ Does the child have any other disabilities? ☐ No ☐ Yes

If Yes, please describe:

REMARKS (You may use the box below to provide any additional information)

I am applying for services from the New York State Commission for the Blind and agree to assist in obtaining information to determine my eligibility for services.

Applicant signature:	Date: / /
Print name of parent/guardian (if applicant is under the age of 18):	
Parent/guardian signature:	Date: / /

PLEASE TURN OVER AND COMPLETE OTHER SIDE

If application is submitted by anyone other than the Applicant or Parent/Guardian of the Applicant, please complete the following and have Applicant or Parent/Guardian sign the FRONT page:			
INDIVIDUAL SUBMITTING APPLICATION:			
First name:		Last name:	
Title/relationship to applicant:			
Signature of submitter:			
Agency (if applicable):			
Address of submitter or agency:	Street:		
	City:	State:	Zip code:
Phone number of Submitter:	( ) -		

DISTRICT OFFICE'S WITH DISTRICT MANAGER'S EMAIL LISTED

Albany - NYSCB
52 Washington St.,
Room 202 South Bldg.
Rensselaer, NY 12144
Email: Ann.Gallagher-Sagaas@ocfs.ny.gov
Telephone: (518) 473-1675

Syracuse - NYSCB
The Atrium
100 S. Salina Str., Suite 105
Syracuse, NY 13202
Email: Amy.Carreno@ocfs.ny.gov
Telephone: (315) 423-5417

Buffalo - NYSCB
Ellicott Square Building
295 Main St., Suite 590
Mail to: Suite 545
Buffalo, NY 14203
Email: Jane.Sullivan@ocfs.ny.gov
Telephone: (716) 847-3516

Rochester – NYSCB-Outstation
259 Monroe Ave., Suite 303
Rochester, NY 14607
Email: Jane.Sullivan@ocfs.ny.gov
Telephone: (585) 238-8110

Westchester - NYSCB
117 East Stevens Ave., Suite 300
Valhalla, NY 10595
Email: Ana.Duraes@ocfs.ny.gov
Telephone: (914) 993-5370

Harlem - NYSCB
Adam Clayton Powell Jr.
State Office Bldg.
163 West 125th St., Suite 1315
New York, NY 10027
Email: Shawn.Chin-Chance@ocfs.ny.gov
Telephone: (212) 961-4440

Lower Manhattan - NYSCB
80 Maiden Lane, Suite 401
New York, NY 10038
Email: Brian.Pinto@ocfs.ny.gov
Telephone: (212) 825-5710

Garden City - NYSCB
711 Stewart Ave., Suite 210
Garden City, NY 11530
Email: Paola.Nappo-Ficcara@ocfs.ny.gov
Telephone: (516) 743-4188

PURSUANT TO THE PROVISIONS OF TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, AND THE REHABILITATION ACT OF 1973 AS AMENDED, AND THE REGULATIONS ISSUED THEREUNDER, THE SERVICES OF THE NEW YORK STATE COMMISSION FOR THE BLIND ARE CONDUCTED IN SUCH A MANNER THAT NO PERSON WILL BE EXCLUDED FROM PARTICIPATION, BE DENIED THE BENEFITS OF, OR BE SUBJECTED TO DISCRIMINATION UNDER SUCH PROGRAM ON THE GROUNDS OF SEX, RACE, AGE, CREED, COLOR, NATIONAL ORIGIN, OR HANDICAP; AND THE STATE AGENCY IS IN FACT ADMINISTERING THE PROGRAM IN ACCORDANCE WITH THE LAW AND THE REGULATIONS.

PURSUANT TO SECTION 504 OF THE REHABILITATION ACT OF 1973, AS AMENDED, NO OTHERWISE QUALIFIED HANDICAPPED INDIVIDUAL IN THE UNITED STATES SHALL, SOLELY BY REASON OF HIS HANDICAP, BE EXCLUDED FROM THE PARTICIPATION IN, BE DENIED THE BENEFITS OF OR BE SUBJECTED TO DISCRIMINATION UNDER ANY PROGRAM OR ACTIVITY RECEIVING FEDERAL FINANCIAL ASSISTANCE.