N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
MEDICAL EYE CARE PROGRAM

NOTIFICATION OF ELIGIBILITY STATUS

Date: ________________

Name and Address of Applicant:

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Dear ____________________________ :

I have reviewed your application for the Medical Eye Care Program and have found you are:

☐ **ELIGIBLE** for these services.

- ☐ Enclosed you will find the forms which you will need to take with you to the optometrist or ophthalmologist of your choice.
- ☐ The services you have requested may require prior approval.
- ☐ If you need eye-related medication, you will need to provide a prescription to the social worker, and if approved your pharmacist will be notified.

☐ **INELIGIBLE** for these services. You are determined ineligible because

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REMARKS:

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If you have questions concerning this determination, please feel free to contact me at

__________________________________ Days and Times: __________________________________
(phone)

Please call the office to be sure I am in before coming by or you may write to me at the following address: ____

Cordially, ______________________________