**APPLICATION**

CONTACT INFORMATION

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Applicant Name:

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Parent Name(s):

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Phone Number: Phone Number (2):

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Street Address:

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City: State: \_\_CO\_\_ Zip Code:

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Date of Birth: Gender:

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Email: Email (2):

DIAGNOSIS DETAILS

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 Primary Diagnosis:

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 Vision Diagnosis:

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 Additional Diagnoses:

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OPHTHALMOLOGIST INFORMATION

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 Doctor Name:

 Clinic Name:

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 Clinic Address:

ADDITIONAL QUESTIONS

 How did you hear about Empowering Vision Foundation?

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 Do you have access to a private TVI, or would you like us to help connect you with one?

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Did your child receive early intervention services before age 3? If yes, with which organization (Anchor Center, A Shared Vision, CSD, other)?

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If your child has received vision services outside of school, please describe them.

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How would funding from Empowering Vision Foundation support you and your child?

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Have you already applied for or requested funding from your community center board?

If not, we can help facilitate this as a first line of funding.

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CATEGORIES REQUESTED FOR FUNDING (CHECK ALL BOXES THAT APPLY)

[ ]  One-to-One In-Home Services

* Independent daily living skills / self-determination / career education
* Low vision aids / enhanced play / adaptive equipment / materials
* Family education and support
* Functional Vision Assessment / Learning Media Plan

[ ]  IEP Support and Tutoring (Reading and School Curriculum)

[ ]  Recreation and Leisure (Navigating the Community with a TVI)

[ ]  Technology Skills / Assistive Technology Training / Eye Gaze Support

[ ]  Orientation and Mobility Training (O&M Instruction)

[ ]  Remote Telehealth Services

[ ]  Group Events / Social Interactions with Other Families

[ ]  Co-Treating and Consultations with Other Providers / Therapists