EMPOWERING VISION
FOUNDATION

APPLICATION

CONTACT INFORMATION

Applicant's Name: _____

Parents' Name(s): _____

Phone Number: _____ Phone Number (2): _____

Street Address: _____

City: _____ County: _____

State: CO Zip Code: _____

Date of Birth: _____ Gender: _____

Email: _____ Email (2): _____

Ethnicity: _____

Total Family Income (this does not affect funding-for grant purposes only):

- ☐ Under $25,000
- ☐ $25,000-$49,999
- ☐ $50,000-$74,999
- ☐ $75,000-$99,999
- ☐ $100,000-$124,999
- ☐ $125,000-$149,999
- ☐ $150,000 and above

DIAGNOSIS

Primary Diagnosis: _____

Vision Diagnosis: _____

Additional Diagnosis: _____

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OPTHAMOLOGIST INORMATION

Doctors Name: _____

Clinic's Office: _____

Clinic's Address: _____

ADDITIONAL QUESTIONS:

How did you hear about Empowering Vision Foundation?

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

Did you receive early intervention services until your child was 3? If so, with which organization? (Anchor Center, A Shared Vision, CSD, other?)

Have you received any additional vision services (outside of school)? If yes, please explain further:

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

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Have you already applied for/requested funding from your community center board (unmet needs, mill levy, family support funds)? If not, we can help facilitate this as a first line of funding.

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 & support/enhanced play/adaptive equipment/materials
- Family education & 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/support (eye gaze)

☐ Orientation and Mobility training (O&M instruction)

☐ Remote telehealth services

☐ Group events/social interactions with other families

☐ Co-Treating and consultations with other providers/therapist

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Acknowledgement

By submitting this application for funding, you hereby acknowledge that your child's participation may be included in our ongoing research and data collections. This helps us show the impact of our program, improve our services, and secure future funding through grants. Any personal information will be kept confidential and only shared in general, anonymous way unless we have your permission to do otherwise.

_____

Parent's or Responsible Party's Signature

*application is good for 1 year.