Insight Vision Center Scholarship Fund
A Nonprofit Corporation
P.O. Box 985
Rancho Santa Fe, CA 92067
(858) 759-4431

Application MUST be received by: _____

CHILDREN'S SCHOLARSHIP APPLICATION FORM

Please answer every question and return it to our office by the deadline indicated on this application.

Today's Date_____

Mail completed form to: Insight Vision Center Scholarship Fund, P.O. Box 985, Rancho Santa Fe, CA 92067
Attn: Scholarship Review Panel

GENERAL INFORMATION

Name of person completing form:_____Relationship to student:_____

Applicant's full name:_____Nickname or Name preference:_____

Male or Female (please circle one) Birth Date:_____ Age: _____

Ethnic Origin (THIS QUESTION IS OPTIONAL):

☐African-American ☐ Asian / Pacific Islander ☐ Hispanic ☐ Native American / Eskimo ☐ White (Non-Hispanic) ☐ Other

Were you referred to our office? Yes ☐ No ☐

If yes, whom may we thank for this referral? _____ Phone: _____

Address: _____

Name and address of school: _____

Grade: _____ Teacher: _____ School Nurse: _____ Principal: _____

School Type (Please circle one): Elementary, Middle, High, Montessori, Charter, Home School, Independent Public, 2-year College, 4-year College, Vocational, other (please specify)_____

Individualized Education Plan (IEP)? Yes ☐ No ☐ (if Yes, complete the box below):

Is the Testing Complete? Yes ☐ No ☐

School District/Court:_____ContactPerson:_____Title:_____

Address:_____City/State/Zip:_____

Phone:_____Fax:_____

RESPONSIBLE PERSON INFORMATION:

Father/Caretaker _____ Birth Date: _____

Mother/Caretaker _____Birth Date: _____

Please circle all that apply: biological, adoptive, step-parent, legal guardian, single, married, re-married, separated, divorced

Home Address: _____ City:_____ Zip: _____

Home Phone:_____Business Phone:_____Email Address:_____

Father/Caretaker's Occupation: _____ Business Phone: _____

Business Address: _____ City: _____ Zip: _____

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Mother/Caretaker's Occupation: _____ Business Phone: _____

Business Address: _____ City: _____ Zip: _____

Do you have Major Medical Insurance? Yes ☐ No ☐

If so, who is the carrier? _____ Policy #: _____

Name of Insured: _____

Have you applied for or do you currently receive other financial aid and/or scholarships (this includes any type of government assistance, church support, spousal support, or family support)? Yes ☐ No ☐

If yes, please list type of support and amount:

1. _____/$_____
2. _____/$_____
3. _____/$_____
4. _____/$_____
5. _____/$_____
6. _____/$_____

Twelve-month Combined Family Income: $_____Year: _____

Size of Family Unit: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Type of Verification enclosed:

☐ Tax Returns – most recent year AND Pay Stubs – two most recent

☐ Other:_____

The Insight Vision Scholarship Fund requires every beneficiary to pay a co-payment for each service received. Full cost Vision Therapy and Comprehensive Examinations can range from $130.00 to $225.00 per session. If vision therapy is recommended, it is likely that one session per week will be required.

How much can you afford to pay per visit? $:_____/per week

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

How did you learn about the Insight Vision Scholarship Fund?

_____

What are your 3 primary reasons for wanting to get your child assessed?

1. _____
2. _____
3. _____

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Please describe your child's academic functions: (please circle one for each function)

Reading: •poor •fair •good

Handwriting: •poor •fair •good

Math: •poor •fair •good

Spelling: •poor •fair •good

Written Output: •poor •fair •good

Coordination: •poor •fair •good

Other: _____

Has your child been assessed previously for learning problems? Yes ☐ No ☐

If yes, where, when and diagnosis?

_____

Does your child receive special educational services? Yes ☐ No ☐

If yes, please describe:

_____

Does your child receive services outside of school? (i.e. occupational therapy, tutoring)? Yes ☐ No ☐

If yes, please describe:

_____

Has your child been diagnosed with any behavioral disorders (i.e. ADHD, Depression)? Yes ☐ No ☐

If yes, please describe:

_____

Is your child receiving treatment? Yes ☐ No ☐

If yes, please describe:

_____

What are your child's future educational goals?

- ❑ High School Diploma
- ❑ GED
- ❑ Community College Certificate Program
- ❑ Community College Degree Program
- ❑ University Degree Program
- ❑ Tech/Trade School Program

Are you willing to share your child's story with other applicants and potential donors? Yes ☐ No ☐

Are you committed to perform 15-20 minutes of home therapy activities with your child a minimum of FIVE days a week? Yes ☐ No ☐

Personal Story

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Describe your child to the scholarship committee and potential donor.

_____

_____

_____

What are your child's interests, hobbies, activities?

_____

_____

_____

Describe your child's short- and long-range goals.

_____

_____

_____

Describe your child's areas of strength and weakness.

_____

_____

_____

Describe any challenges faced by your child and his/her response.

_____

_____

_____

What are your child's future career goals?

_____

_____

_____

C.O.V.D. Quality of Life Checklist

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PATIENTS NAME_____ AGE: _____ DATE _____

Completed by: _____

Circle the number that best represents the occurrence of each symptom.
If applicable, please complete with your child's input.

Symptoms	Never	Seldom	Occasionally	Frequently	Always	Score
Blur when looking at near	0	1	2	3	4	
Double vision, doubled or overlapping words on page	0	1	2	3	4	
Headaches while or after doing near vision work	0	1	2	3	4	
Words appear to run together when reading	0	1	2	3	4	
Burning, itching or watery eyes	0	1	2	3	4	
Falls asleep when reading	0	1	2	3	4	
Seeing and visual work is worse at the end of the day	0	1	2	3	4	
Skips or repeats lines while reading	0	1	2	3	4	
Dizziness or nausea when doing near work	0	1	2	3	4	
Head tilts or one eye is closed or covered when reading	0	1	2	3	4	
Difficulty copying from the chalkboard	0	1	2	3	4	
Avoids doing near vision work such as reading	0	1	2	3	4	
Omits (drops out) small words while reading	0	1	2	3	4	
Writes up or down hill	0	1	2	3	4	
Misaligns digits or columns of numbers	0	1	2	3	4	
Reading comprehension low, or declines as day wears on	0	1	2	3	4	
Poor, inconsistent performance in sports	0	1	2	3	4	
Holds books too close, leans too close to computer screen	0	1	2	3	4	
Trouble keeping attention centered on reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
First response is "I can't" before trying	0	1	2	3	4	
Avoids sports and games	0	1	2	3	4	
Poor hand/eye coordination, such as poor handwriting	0	1	2	3	4	
Does not judge distances accurately	0	1	2	3	4	
Clumsy, accident prone, knocks things over	0	1	2	3	4	
Does not use or plan his/her time well	0	1	2	3	4	
Does not count or make change well	0	1	2	3	4	
Loses belongings and things	0	1	2	3	4	
Car or motion sickness	0	1	2	3	4	
Forgetful, poor memory	0	1	2	3	4	

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OTHER COMMENTS:	TOTAL SCORE 20-24 pts. = Suspect 25 pts. or more = Refer for Care

INCLUDE WITH COMPLETED APPLICATION:

- A recent photograph of the applicant.
- A copy of the applicant's most recent academic progress report (report card) and/or proof of enrollment.
- A copy of the front page of the most recent federal tax return (or parent/guardian's federal tax return, if the applicant is claimed as a dependent) and a copy of two most recent pay stubs. Documentation of public assistance (i.e. TANF statement) will be accepted in lieu of these other forms.

****LATE AND/OR INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED. DATE OF POSTMARK WILL NOT BE CONSIDERED. FAXED APPLICATIONS WILL NOT BE CONSIDERED. ****

To the best of my knowledge the information provided in this application is true and correct. I will make myself available for a personal interview as part of this application process. If chosen as a scholarship recipient, I agree to permit information from, or copies of this application, photograph and records included with this application to be shared with potential donors and the Clinical Center in which treatment will be received by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

_____ _____

Signature Date

_____

RELATIONSHIP TO APPLICANT

DO NOT WRITE BELOW THIS LINE

Application Deadline:	Application Rec'd on:	Reviewed:
Interview Scheduled:	Held:	Decision: