Vision Forward Association

Growing Through Vision Loss

INSURANCE LETTER FOR CHILDREN 3 AND OVER

Date:_______________

Child's Name: ___________________
Child's DOB: ____________________

Please select one:

☐ I have provided a copy of my child's IEP for insurance. My child will receive medical therapies at Vision Forward Association.

☐ My child does not have an IEP and we have decided not to pursue one at this time. We will be receiving therapies at Vision Forward Association.

☐ My child will be receiving educational therapies at our public school and medical therapies at Vision Forward Association.

☐ Other:

_______________/_______________
Parent Signature and Printed Name

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