

The Emporia Community Foundation

Sadie Jones Fund

Purpose:

The Sadie Jones Fund is available as a funding resource for children in Lyon and Chase Counties. This fund was established to meet medical needs of these children with special emphasis on providing funds for children with vision and/or hearing needs.

Guidelines:

- Children must be under the age of 18
- Children must be living in Lyon or Chase County at the present time
- Applicant must have "financial need"
- Only one application will be taken per year for glasses
- Application for funding MUST be pre-approved and must have school nurse or professional signature on application

Application Process:

Funds must be PRE-APPROVED. Potential recipients must complete an application for funding **PRIOR** to possible approval. The application can be found at the bottom of these instructions.

Applications are also available at the Emporia Community Foundation. All completed applications must be mailed or faxed to the following address:

The Emporia Community Foundation/ Sadie Jones Fund
P.O. Box 1337
Emporia, Kansas 66801-1337
Fax Number: 620-342-6025

Notification of Funding:

Applicants will receive notification of approval or denial within one week of receipt of completed application. It should be noted that while the fund is to assist with the medical needs of children in Lyon and Chase Counties, the grants committee of the Emporia Community Foundation interpret "medical needs" broadly to include a variety of physical and/or emotional needs. All work is to be completed within three months of the authorization date. Additionally, the grants committee will determine financial need and their decision is final.

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Sadie Jones Fund

P.O. Box 1337

527 Commercial St. Ste. 401

Emporia, KS 66801-1337

Application

Date: _____

Name: _____

Age: _____

Parent's or Guardian's Name: _____

Address: _____ Phone: _____

City: _____ Chase County: _____ Lyon County: _____ St: _____ Zip: _____

Number of Dependent Children in home: _____ Spouse's Name: _____

Parental or Guardian's Employment: _____ Income: _____

Other Income amounts and source: (eg. public assistance, SSI, Child Support)

Free Lunch Program _____ Reduced Lunch Program _____ No Lunch Program: _____

Please List Assets and Liabilities on other side:

Type of Assistance Requested: _____

_____ Amount Requested: _____

Do you have Insurance or a medical card which may help with this request? _____

Medical Provider(s): _____

Other Comments: _____

Signed by: Applicant's guardian or Parent: _____

Signed by: School Nurse or Para/Professional: _____

NOTE: APPLICATIONS MUST BE SUBMITTED PRIOR TO TREATMENT

For Office Personnel only:

Approved: _____ Amount: _____ Not Approved: _____