

# 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  
527 Commercial St, Ste B  
Emporia, Kansas 66801

### **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.

**The Emporia Community Foundation**

Sadie Jones Fund  
527 Commercial St. Ste. B  
Emporia, KS 66801

**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: \_\_\_\_\_