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: _____________