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 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 emailed to emporiacf@emporiacf.org OR delivered to the following address:

Sadie Jones Fund
Emporia Community Foundation
527 Commercial St, Suite 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.

Emporia Community Foundation

Sadie Jones Fund Individual Application

527 Commercial St. Suite B
Emporia, KS 66801

Date: _____

Name: _____ Age: _____

Parent's or Guardian's Name: _____

Address: _____ Phone: _____

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

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

Parent 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 another sheet.

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:

_____

_____

_____

Signature from Applicant's Parent or Guardian:_____

Signature from School Nurse: _____

NOTE: **APPLICATIONS MUST BE SUBMITTED PRIOR TO TREATMENT**

For Office Personnel only:

Approved: _____ Amount: _____ Not Approved: _____