Riverfest Commodore Foundation
Kids in Need
FUND

Application for Assistance

- Grants are available for children ages 0 – 18
- The child must have a specific health care need, condition, or diagnosis
- Grant requests will be considered from the following areas:
  - Wisconsin Counties: La Crosse, Buffalo, Crawford, Jackson, Richland, Trempealeau, Vernon
  - Minnesota Counties: Fillmore, Houston, and Winona
  - Iowa Counties: Allamakee and Winneshiek
- One request per year per child
- Grants are considered on a case-by-case basis
- Grants are intended to serve families who do not have other funding options available to them for the requested service
- When appropriate, families may be directed to other programs/resources that may be able to meet their needs
- If approved, payment will be sent to the provider of services

Eligible Expense Examples (this is not an all-inclusive list):

- Therapy
- Equipment
- Therapeutic Programs

If you are not sure if your request meets the above criteria, please contact Kids in Need at **phone # or **email***

- Home Modifications
- Therapy Dogs

Submittal Checklist:

- ☐ **Completed application**
- ☐ **Letter from provider on letterhead showing the cost of the service or equipment**
- ☐ **Letter of denial from the insurance company or policy showing high deductible or exclusion**

Submit completed applications with supporting documents to:

Kids in Need

PO Box

La Crosse, WI 54603

Phone #

Email

Fax

Website

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CHILD INFORMATION

Last Name _____ First Name_____

Male _____ Female _____ DOB _____ Age _____

FAMILY INFORMATION

Guardian #1

First Name _____Last Name _____ Occupaton _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Guardian #2

First Name _____Last Name _____ Occupaton _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

MEDICAL INFORMATION

Physician's name and clinic: _____

Social Worker's name (if applicable): _____

Child's Clinical Diagnosis: _____

Age at Diagnosis: _____ History of Illness or Diagnosis: _____

_____

HOUSEHOLD INFORMATION

Child Lives With _____ Number of Dependent Children in the household_____

Does the household speak English? Yes _____ No _____ Language spoken if not English _____

Annual Income of Household

- ☐ $0 - $30,000
- ☐ $30,001 - $60,000
- ☐ $60,001 - $90,000
- ☐ $90,001 - $120,000
- ☐ $120,001+

How did you hear about Kids in Need? _____

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FUNDING INFORMATION

Amount Requested from Kids in Need: $_____

Description of Request: _____

Has funding been requested from additional source? Yes ___ No ___ If yes, please list _____

If funding has been received, from whom: _____ Amount Received $_____

Is the child covered by private or employer-sponsored Health Insurance? Yes _____ No _____

Annual deductible amount: Individual _____ Family _____

Is the child covered by Medicaid? Yes ____ No ____

****Denial letter, exclusion of service, or proof of deductible must accompany application**

REQUEST FOR TREATMENT/SERVICES *(therapy, surgery, clinic visit, procedures, etc)*

Type of Treatment _____

# of Treatments/Visits _____ Out-of-Pocket Cost per Treatment/Visit $_____

Company/Provider that the check will be made out to _____

Address _____ City _____

State _____ Zip _____ County _____

****Attach statement from provider on letterhead indicating cost of service/treatment and treatment plan**

REQUEST FOR EQUIPMENT/SUPPLIES

Type of Equipment/Supplies _____ Cost $_____

Company/Provider that the check will be made out to _____

Address _____ City _____

State _____ Zip _____ County _____

REQUEST FOR OTHER NEEDS

Other need (not addressed above) _____

Company/Provider that the check will be made out to _____

Address _____ City _____

State _____ Zip _____ County _____