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 La Crosse and surrounding area
- ❑ One request per calendar 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
- ❑ If approved, payment will be sent to the provider of services within 60 days of grant approval
- ❑ Checks are sent to service provider only

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

- ❑ Therapy
- ❑ Therapeutic Programs
- ❑ Medical/Mobility Equipment
- ❑ Adaptive Equipment
- ❑ Medical Expenses

**If you are not sure if your request meets the above criteria or if you are not sure if your area is served by Kids in Need, please contact us at laxkidsinneed@gmail.com*

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 by mail or email to:

Kids in Need
PO Box 244
Onalaska, WI 54650-0244
laxkidsinneed@gmail.com

Riverfest Commodore Foundation
Kids in Need
FUND

DATE _____

CHILD INFORMATION

Last Name _____ First Name_____

DOB _____ Age _____

MEDICAL INFORMATION

Child's Clinical Diagnosis:_____

Physician's name and clinic_____

Age at Diagnosis: _____ History of Illness or Diagnosis: (attach another page if needed)

_____

_____

_____

FAMILY INFORMATION

Guardian #1

First Name _____Last Name _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Guardian #2

First Name _____Last Name _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

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FUNDING INFORMATION

Amount Requested from Kids in Need: $_____

Service or Equipment
Requested:_____

Price per visit of service or full cost of equipment: _____

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

If funding has been received, from whom: _____

Amount Received or Committed $_____

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

Annual deductible amount: _____

Is the child covered by Medicaid? Yes ____ No ____

Is the child covered by the Children's Waiver program or other County funding? Yes _____ No _____

If yes, name of County and Social Worker _____

Provider or Vendor Name: _____

Address _____ City _____

State _____ Zip _____

_____ _____

Signature of Person Completing the Form *Date*