Gartner Child Assistance Fund
Guidelines and Application

3 Rivers Community Foundation facilitates the Gartner Child Medical Assistance Fund. This fund originated through the Family Health and Wellness Foundation (formerly Trios Foundation, formerly KGH Foundation). This fund provides grants to providers to pay for medical assistance to qualified children based on the following eligibility requirements.

Eligibility:

1. The child is under 12 years of age.
2. The child has not received any previous aid from the Gartner Child Assistance Fund.
3. The child has a reasonable possibility of recovery.
4. The child has a documented illness, injury, or medical need that is not terminal.
5. The child has a reasonable possibility of having an improved life due to medical treatment.
6. The child's family has a documented financial need.
7. The child resides in Benton or Franklin counties.

Distributions:
Grants will be distributed directly to the medical provider, or adaptive equipment/devices will be purchased by the fund. Grants will not be distributed to individuals/families.

How to Apply:

The application must be submitted and receive pre-approval in advance of treatment/therapy to be eligible for the grant.

Required Documents (incomplete applications will not be considered):

1. Medical Documentation Form from medical provider/therapist.
2. Financial Need Form (Organization) **or** Financial Need Form (Individual)

Gartner Child Assistance Fund
Medical Documentation Form

Must be completed by medical provider/therapist

Name of Practice:_____
Provider Name:_____
Physical Address:_____
Mailing Address:_____
Phone: _____Email:_____

Patient Details:

Patient Age:_____ Patient City of Residence:_____
Patient Gender:_____ Patient Race/Ethnicity (if known):_____

Patient Medical Need (use additional page as needed):

Cost of Procedure/Therapy/Treatment/Equipment (attach documentation if needed):_____
Insurance or other funding (attach documentation):_____

Patient Financial Need/Grant Amount Requested:_____

I certify that (initial each):

_____ The above information is correct and complete
_____ The patient has a reasonable possibility of recovery
_____ The patient has a documented illness, injury, or medical need that is not terminal
_____ The patient has a reasonable possibility of having an improved life due to medical treatment

_____ _____
Medical Provider Signature Date

Financial Need Form (individual)

Number of people in household (total):_____
Number of Adults in household:_____
Number of Children in household:_____
Monthly Income:_____
Are any students in your household approved for free or reduced lunch at school?:_____

Please provide one of the following:

- Copy of Washington State Apple Health card/proof of coverage
- Copy of denial letter from insurance and/or Medicaid if applicable

Financial Narrative

If there are specific circumstances that you would like to be considered please detail here (such as job loss, homelessness or displacement, loss of work hours, other expenses, etc.):

I certify that the above information is correct and complete:

_____ _____

Parent/Guardian Signature Date