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 (Organization)

Organization:____
Contact:____
Address:____
City:___________________________ State:______________ Zip: ________________________________
Phone: __________________________Email:____

Please describe your organization's process for verifying financial need, including what type of information you requested from the family to make your determination:

______ *Initial* I attest that the child in need of treatment is a client of our organization, and that we have verified the family's financial need.

__________________________ _________________

Organization Contact Date