The Walter S. & Evan C. JONES FOUNDATION
Serving Children in the Kansas Counties of Coffey, Lyon and Osage

MEDICAL GRANT APPLICATION

Completing this application does not guarantee the Jones Foundation's acceptance of your application nor award any financial grant. The Jones Foundation will not pay for requested health care services or treatment for your child(ren) until this application has been processed in full and provided you with an Acceptance Letter.

This application must be hand delivered or mailed to the Jones Foundation as quickly as possible or the Jones Foundation may no longer consider your child(ren) eligible for a financial grant.

You must provide copies of the following:

- **PREVIOUS YEAR COMPLETE TAX RETURN**
- **MOST RECENT PAYSTUBS REFLECTING YEAR TO DATE EARNINGS**
- **PROOF OF ALL ADDITIONAL MONTLY INCOME FOR PREVIOUS YEAR, as listed on page 2**
- **COPIES OF MEDICAL AND DENTAL INSURANCE CARDS**
- **COPY OF STATE ISSUED BIRTH CERTIFICATE FOR EACH CHILD FOR WHOM YOU ARE REQUESTING ASSISTANCE**

Today's Date: _____ **Referred By:** _____

Child's Information (all for whom you are applying):

Legal Name: _____ SSN (last 4 digits):_____

Age: _____ DOB: ___/____/_____ Sex: M◯ F◯ Birth Certificate: Y◯ N◯

Legal Name: _____ SSN (last 4 digits):_____

Age: _____ DOB: ___/____/_____ Sex: M◯ F◯ Birth Certificate: Y◯ N◯

Legal Name: _____ SSN (last 4 digits):_____

Age: _____ DOB: ___/____/_____ Sex: M◯ F◯ Birth Certificate: Y◯ N◯

Legal Name: _____ SSN (last 4 digits):_____

Age: _____ DOB: ___/____/_____ Sex: M◯ F◯ Birth Certificate: Y◯ N◯

Parent(s)/Legal Guardian(s) Household Information

Marital Status: Married◯ Divorced◯ Separated◯ Single (never married) ◯ Living together◯

Custodial Parent First Name _____Last Name _____ Relationship to Child_____

Street Address_____City_____State_____ Zip_____

Preferred Phone _____Email_____ (used only for contact regarding application)

Custodial Parent Employer _____# of years _____

Payroll Frequency: Weekly ◯ Bi-Weekly ◯ Monthly ◯ Semi-Monthly ◯

Spouse/Partner First Name _____Last Name_____ Relationship to Student _____

Preferred Phone _____Email_____ (used only for contact regarding application)

Spouse/Partner Employer _____# of years _____

Payroll Frequency: Weekly ◯ Bi-Weekly ◯ Monthly ◯ Semi-Monthly ◯

Number of Dependent Children in home _____

Are you required to file taxes? Y ◯ N ◯ If no, why not? _____

Is the child(ren) for which you are applying listed as a dependent on your tax return? Yes ◯ No ◯
If no, why not? _____

If you or anyone in your household currently receives any of the additional income below, provide monthly amounts received.

Cash Assistance $_____Mo. Child Support $_____Mo. Death Benefits $_____Mo. Disability $ _____Mo.

Food Stamps $ _____Mo. Military $ _____Mo. Retirement $ _____Mo. SSI $ _____Mo. Unemployment $ _____

Additionally, in the previous year, if you or anyone in your household received any of this income, you must include proof of total amount received from January 1st through December 31st.

Will household income be less than previous year? Yes ◯ No ◯ If yes, explain below and be specific.

Loan value of your home & acreage, if you are purchasing or own your home $_____

Amount of acreage included (if any) _____ Current payoff amount of mortgage $_____

Monthly rent amount, if renting $_____

Name of individual/business to whom rent is paid _____

Itemize below all vehicles, including, but not limited to, motorcycles, RVs, and watercraft. If nothing is owed, enter $0.00 in Payoff Amount. (If additional space is needed, use separate sheet.)

YEAR	MAKE/MODEL	PAYOFF AMT
		$
		$
		$
		$

Itemize below all Additional Assets.' This includes, but is not limited to, ALL savings, retirement and college savings plans, investment accounts, rental property, additional land, business property and equipment, farm equipment, livestock, crops, etc... List all property by physical address. If additional space is needed, use separate sheet.

Savings, Retirement & College Savings Plans, Investment Accounts, etc…	Market Value	Loan
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
Total Amount	**$**	**$**

Rental Property, Business Property & Equipment, Farm Equipment, Livestock, Crops, etc…	Market Value	Loan
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
Total Amount	**$**	**$**

In 'Debts', provide the total payoff balances for any additional bills you owe other than what is previously listed. Do not include your mortgage amount or vehicle loan amounts.

Total of all Medical/Dental Bills	$
Total of all Credit Cards	$
Total of all Other Outstanding Loans	$

Child Provider Information

Provide information for only those providers with whom you are requesting assistance. This information is required, as it provides The Jones Foundation the necessary contact information for us to request and receive the needed information to process your grant request. (If additional space is needed, use a separate sheet.)

1. Medical

Doctor:_____ Office Address_____
First Last

City, State, ZIP _____Phone with Area Code _____

Date of child's last visit: _____
MM/DD/YY

2. Counseling

Counselor:_____
First Last Business Name

Office Address_____

City, State, ZIP _____Phone with Area Code _____

Date of child's last visit: _____
MM/DD/YY

3. Dental

Dentist:_____ Office Address_____
First Last

City, State, ZIP _____Phone with Area Code _____

Date of child's last visit**:**_____
MM/DD/YY

4. Oral Surgery

Office Name:_____ Office Address_____

City, State, ZIP _____Phone with Area Code_____

Date of child's last visit: _____
MM/DD/YY

Acknowledgement

By completing this form and signing below, I acknowledge and agree to the following statements:

- This form is an application only. Completing this form does **NOT** guarantee receipt of a Jones Foundation medical grant.

- The Jones Foundation reviews each application to determine whether qualifications and eligibility for financial assistance have been met. The Foundation's Board of Trustees, in its sole discretion, has the final decision regarding the qualification, eligibility, and the amount of financial assistance to be awarded.

- All information provided in this application and its supporting documentation is true and accurate to the best of my knowledge and belief. I am providing this information voluntarily. I understand that intentional misstatements or falsification of the information in this application or any supporting documentation will void this application and result in the immediate loss of eligibility to receive a Jones Foundation medical grant.

- I certify that each child named in this application (i) is a United States citizen, (ii) is under the age of 21, (iii) resides in Coffey, Lyon, or Osage County and (iv) has continuously resided in Coffey, Lyon, or Osage County for **no less** than one year immediately prior to the date on this application. **I will immediately inform the Jones Foundation if this information changes in any way.**

- I understand that I must maintain residency in Coffey, Lyon, or Osage County to maintain eligibility for a Jones Foundation medical grant. **I understand that failure to maintain residency in these counties may result in the immediate loss of the Jones Foundation medical grant, if awarded.**

- All information provided in this application and its supporting documentation may be reviewed by the Jones Foundation staff and its Board of Trustees. I authorize the review of the information provided herein, including any protected health information, by the Jones Foundation staff and its Board of Trustees to determine eligibility for the medical grant. I authorize the Jones Foundation staff to contact those certain providers named in this application to verify or supplement the information provided in the application or supporting documentation.

Restrictions on Use or Disclosure of Information

I request that the Jones Foundation **NOT** release to or discuss the information provided herein or attached with the following individuals:

Name:_____ Relationship_____

Name:_____ Relationship_____

Signature

Applicant Father's Signature: _____ Date _____

Applicant Mother's Signature: _____ Date _____

Applicant Legal Guardian's Signature: _____ Date _____

Applicant Signature: _____ Date _____

**Required if Applicant is over the age of 18 as of the date of this Application.*

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize/give permission for the use or disclosure of the patient's health information as described below:

Patient Name (please print) Birth Date

Address (Street, City, State, Zip Code—no PO Boxes, please)

RELEASE TO:

Walter S. & Evan C. Jones Foundation
(Its Employees, Agents and Representatives)
2501 W. 18th Ave., Suite D
Emporia KS 66801

RELEASE FROM/BY:

THE FOLLOWING INFORMATION IS TO BE DISCLOSED:

☐ Complete Medical Records ☐ Dental Records ☐ Intake Screening
☐ Progress Notes ☐ Itemized Billing Statement ☐ Insurance EOB via mail or fax
☐ Other

PURPOSE OF THIS REQUEST: Assistance in paying my patient account balances.

RIGHT TO REVOKE: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released based upon this authorization.

EXPIRATION: This authorization expires one year from date of signature unless I have indicated otherwise:
_____ (in any case, cannot exceed one year).

SENSITIVE INFORMATION: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about Behavioral or Mental Health services, treatment for Alcohol or Drug Abuse.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules. I give specific permission for this information to be disclosed / released.

If I have questions about disclosure of my health information, I may contact The Jones Foundation at **620.342.1714.**

Signature of Applicant / Father / Mother / Guardian / DPOA (Circle one) Date

Legal Personal Representative (*e.g.*, Parent, Guardian) / Authority to Act for Patient Telephone Number

Legal Personal Representative Address (Street, City, State, Zip Code)

Walter S. & Evan C. Jones Foundation Representative Date