Gartner –
Child Assistance Fund Application

Medical or therapeutically professionals MUST submit the application to the Three Rivers Community Foundation (3RCF) to receive pre-authorization for the child to receive an assistance grant from the Family Health and Wellness Foundation Fund. For questions or assistance in completing this application, contact the 3RCF Office at 509-735-5559.

The Family Health and Wellness Foundation Fund grants medical assistance to qualified children based on the following eligibility requirements provided resources are available.

In order to receive assistance, the child must meet the following eligibility requirements:

1. is under 12 years of age;
2. has never before received any aid from the Gartner - Child Assistance Fund;
3. has a reasonable possibility of recovery;
4. has a documented illness or injury that is not terminal;
5. has a reasonable possibility of having an improved life due to the medical treatment; and,
6. has a documented financial need, (the child/family is eligible for federal or state assistance and there is no other source of payment for medical bill).

ATTACHMENTS:

All applicants must attach copies of the following. **Incomplete applications will be denied.**

One of the following;

1. Copy of Washington State Apple Health (Medicaid) card/proof of coverage.
2. Copy of denial letter from insurance and /or Medicaid if applicable.

FOR THREE RIVERS COMMUNITY FOUNDATION USE ONLY
Medical Professional Submitting Application: _____ Date:_____ 3RCF Representative Accepting Application: _____ Date:_____
Approved: _____ Rejected: _____ Date:_____
3RCF Representatives Approval: President / Committee Chairperson:_____Date:_____ Executive Director:_____Date:_____

FINANCIAL ASSISTANCE APPLICATION

Please answer all questions completely and to the best of your knowledge in order to prevent delaying this application.

Name:_____Phone #:_____

Address (if a P.O. Box include physical location):

_____

Describe the kind of assistance are you asking for. Please be specific.

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Household & Employment Information. List all persons living in household.

NAME	RELATIONSHIP / AGE	INSURANCE COVERAGE

Parents / Guardian Information:

Employment Status: Father: Unemployed_____Part Time:_____Full Time:_____
Mother: Unemployed_____Part Time:_____Full Time:_____
Guardian: Unemployed_____Part Time:_____Full Time:_____

Father's current employer: _____

Employer Address: _____

Phone: _____ Length of employment _____

Mother's current employer: _____

Employer Address: _____

Phone: _____ Length of employment _____

Guardian's current employer: _____

Employer Address: _____

Phone: _____ Length of employment _____

If unemployed, list past employment:

Father's last employer: _____

Employer Address: _____

Phone: _____ Date last employed _____

Mother's last employer: _____

Employer Address: _____

Phone: _____ Date last employed _____

Guardian's last employer _____

Employer Address: _____

Phone: _____ Date last employed _____

I certify that the above information is correct and complete. Further, I authorize the 3RCF to contact the employers and institutions on this application to verify accuracy. I further authorize the employer/institutions to release such information to the 3RCF.

Applicant Signature _____Date _____

Photo/Video/Interview Consent Form
Authorization to Use/Disclose Protected Personal Information

For value received and without further consideration or compensation, I hereby consent to the use (in full or in part) of all video and/or photos taken of me and/or recordings made of my voice and/or written extraction, in whole or in part, of such recording or musical performance for the purposes of illustration, broadcast, or distribution in any manner by the Three Rivers Community Foundation on behalf of the Family Health and Wellness Foundation Fund,

I have willingly participated in the described materials. I understand that I may appear in a Three Rivers Community Foundation on behalf of the Family Health and Wellness Foundation Fund publication, production or advertisement.

I understand that it is my right to request cessation of the production of the recordings, films or other images.

I understand that:

A. Authorizing a disclosure of health information is voluntary.
B. I have the right to revoke this authorization at any time by providing written notice to the Family Health and Wellness Foundation.
C. If I revoke this authorization, the revocation will not apply to information that has already been disclosed in reliance on this authorization.
D. Once information is disclosed, it may be subject to re-disclosure by the recipient and may not be protected by federal and state privacy laws.

This authorization will expire on (insert date) _____. If not specified, this authorization will not expire.

PLEASE PROVIDE ONE COPY TO THE PATIENT. ONE COPY TO THREE RIVERS COMMUNITY FOUNDATION.

_____
Name of Child or Adult (please print)

_____ _____
Name of Legal Guardian (if under 18 years of age) Signature of Parent/Guardian Adult

_____ _____
E-mail Address Telephone