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 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 available to them for the requested service
- ❑ When appropriate, families may be directed to other programs/resources that may be able to meet their needs
- ❑ If approved, payment will be sent to the provider of services
- ❑ Grants may not cover the full cost of all services

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

- ❑ Therapy
- ❑ Equipment
- ❑ Therapeutic Programs
- ❑ Home Modifications
- ❑ Therapy Dogs

**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

CHILD INFORMATION

Last Name ________________________________ First Name______________________________

Male _____ Female _____ DOB __________ Age ________

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 ___________________________

MEDICAL INFORMATION

Physician's name and clinic: ____

Social Worker's name (if applicable): ____

Child's Clinical Diagnosis: ____

Age at Diagnosis: ______ History of Illness or Diagnosis: ____________________________________

____

HOUSEHOLD INFORMATION

Child Lives With _________________________________ Number of Dependent Children in the household_______

Does the household speak English? Yes _____ No ______ Language spoken if not English ____________________

Annual Income of Household

- ❏ $0 - $30,000
- ❏ $30,001 - $60,000
- ❏ $60,001 - $90,000
- ❏ $90,001 - $120,000
- ❏ $120,001+

FUNDING INFORMATION

Amount Requested from Kids in Need: $_______________

Description of Request: ____

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

If funding has been received, from whom: _________________________________ Amount Received $____________

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

Annual deductible amount: Individual ____________ Family ____________

Is the child covered by Medicaid? Yes ____ No ____

****Denial letter, exclusion of service, or proof of deductible must accompany application**

REQUEST FOR TREATMENT/SERVICES *(therapy, surgery, clinic visit, procedures, etc)*

Type of Treatment ____

# of Treatments/Visits _________ Out-of-Pocket Cost per Treatment/Visit $__________

Company/Provider that the check will be made out to ____

Address ____ City ____________________________

State ___________ Zip _______________ County ____________________________

****Attach statement from provider on letterhead indicating cost of service/treatment and treatment plan**

REQUEST FOR EQUIPMENT/SUPPLIES

Type of Equipment/Supplies ____ Cost $________________

Company/Provider that the check will be made out to ____

Address ____ City ____________________________

State ___________ Zip _______________ County ____________________________

REQUEST FOR OTHER NEEDS

Other need (not addressed above) ____

Company/Provider that the check will be made out to ____

Address ____ City ____________________________

State ____________ Zip ________________ County ______________________________