



Return form to:  
amambucsassistance@gmail.com

**APPLICATION FOR ASSISTANCE**

MORNING AMBUCS  
P.O. BOX 1952  
SALINA, KS 67401

Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Age: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Applicant's Address: \_\_\_\_\_

Phone numbers: Home: \_\_\_\_\_

Work: \_\_\_\_\_

(Adult applicant) Applicant's Occupation: \_\_\_\_\_ Annual Income: \_\_\_\_\_

(Child applicant) Father's Occupation: \_\_\_\_\_ Annual Income: \_\_\_\_\_

(Child applicant) Mother's Occupation: \_\_\_\_\_ Annual Income: \_\_\_\_\_

Number in Family: \_\_\_\_\_

Physician or Therapist & Phone number: \_\_\_\_\_

Disability or Medical diagnosis: \_\_\_\_\_

Explanation of need: *(continue on back if needed)* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Requested cost: \$ \_\_\_\_\_ Insurance Provider: \_\_\_\_\_

List all other funding resources contacted: \_\_\_\_\_

\_\_\_\_\_

Unusual expenses/circumstances or other pertinent information related to this request: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ *(Continue on back if needed)*

Signature of Applicant or Parent: \_\_\_\_\_

*\*My signature indicates that I give permission to the Morning Ambucs Allocations chair- person to contact the above persons to obtain information related to this allocation request.*

Referred to Ambucs by: \_\_\_\_\_ Phone contact: \_\_\_\_\_