



Creating Mobility and Independence for People with Disabilities

APPLICATION FOR ASSISTANCE

SALINA, KS AM CHAPTER · P.O. Box 1952 · Salina, KS 67402-1952

DATE _____

CHILD'S NAME _____ CHILD'S AGE _____

PARENT'S NAMES _____ NUMBER IN FAMILY _____

STREET ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____

FATHER'S OCCUPATION _____ ANNUAL INCOME \$ _____

MOTHER'S OCCUPATION _____ ANNUAL INCOME \$ _____

FATHER'S WORK PHONE _____ MOTHER'S WORK PHONE _____

PHYSICIAN'S NAME _____ PHONE _____

PHYSICIAN'S ADDRESS _____

IF MORE ROOM IS NEEDED IN THE NEXT SECTION, PLEASE CONTINUE ON THE BACK OF THIS FORM

CHILD'S MEDICAL PROBLEM _____

THERAPY OR ASSISTANCE NEEDED _____

EXPECTED COST \$ _____

LIST ANY INSURANCE OR OTHER COVERAGE AVAILABLE _____

UNUSUAL EXPENSES OR CIRCUMSTANCE OR OTHER PERTINENT INFORMATION _____

SIGNATURE OF APPLICANT _____

REFERRED TO AMBUCS BY _____ PHONE _____

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