SSCFPD Auxiliary
Benevolence Fund Application

Date of Request:_____

Name & phone # of Individual Making Request:_____

Name & phone # of Firefighter/District Personnel Needing Funds:_____

Name of Immediate Family Member Needing Funds:_____

Amount Requested:_____

Is this an immediate request (48 hr)? _____ Yes _____ No

Monetary Need:_____

_____
IE: Electric bill, Travel Expenses, Medical Bill, etc.

Have they missed work because of this situation? _____Yes _____No
If yes, how much?_____

Describe Circumstances: *Be as specific as possible. (Feel free to use the back if needed)
_____
_____
_____
_____
_____

* The Auxiliary has the right to refuse anyone & approval of requests will be based on available funds.

Other Available Resources

Christian Associates
417-739-3200

Oacac Neighborhood Center
417-272-8508

Stone County Health Dept.
417-272-0050

Division of Family Services
417-357-6118

_____Date Approved

_____Date Not Approved

Revised 1/10/19