UNWAVERING SUPPORT
FOR UNCOMMON HEROES

Application for Medical Assistance Grant

VFW AUXILIARY – DEPARTMENT OF CALIFORNIA

Complete and mail one copy directly to the Department President Diana Russell-Milton, c/o CA-Dept. Office, 9136 Elk Grove Blvd., Suite 101, Elk Grove, CA 95624.

AUXILIARY NAME _____ # _____ DISTRICT _____

NAME OF AUXILIARY MEMBER _____

Date joined auxiliary _____ Date current year's dues paid _____

Date previous year's dues paid _____ Marital Status_____

Does Member (or Spouse) have hospitalization insurance? _____

OR **Medicare**?_____

Name of Insurance Company_____

Name of Hospital and length of Hospital Stay_____

Percentage of Hospital bills paid by insurance _____(copy of hospital showing what insurance does not pay)

Member has ___ has not _____received a previous hospital grant (if so, give date) _____

Please advise (in detail) why you feel this Member needs assistance.

_____

_____

_____

Approved by Auxiliary Treasurer

_____Date _____

Address:

_____Zip_____

(Approved assistance will be mailed and paid directly to the member at the address on record in MALTA).

PHYSICIAN'S STATEMENT

Name and location of Hospital (if hospitalized)

_____

Date confined from _____ **to** _____

Diagnosis_____

_____

_____

Prognosis:_____

_____

Signed:

_____

Physician's Signature Date

_____

Physician's Address

Application Granted [ ] Denied [ ] Date _____Amount $_____

If Grant was denied, please explain reason for denial:

_____
_____
_____
_____
_____
_____