Application for Medical Assistance Grant
VFW AUXILIARY - DEPARTMENT OF CALIFORNIA

Complete and mail one copy directly to the Department President: President Angela Prill, 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 CODE_____

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