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 Robyn Kuznik, 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? _____
Medicare?_____
Percentage of Hospital bills paid by insurance _____
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_____

****

PHYSICIAN'S STATEMENT

Name and location of Hospital (if hospitalized)_____

_____

Date confined from _____ **to** _____

Diagnosis: _____

_____

Prognosis:_____

Signed

_____

Physician's Signature

_____

Physician's Address

Application Granted [ ] Denied [ ] Date _____Amount $_____

If Grant was denied, reason for denial:

_____

_____

_____