LADIES AUXILIARY, V.F.W. – DEPARTMENT OF CALIFORNIA

APPLICATION FOR MEDICAL ASSISTANCE

(SEE REVERSE SIOE FOR INSTRUCTICNS}

Complete and mail one copy directly to the Department President without delay.

AUXILIARY NAME ______________________________ # _________ DISTRICT ___________
NAME OF MEMBER ____________________________________ AGE ____________________
Date joined auxiliary ____________________ Date current year's dues paid ____________________
Date previous year's dues paid ___________________ Status of Husband ______________________
{employed. retired, deceased)

Does member (or Husband) have hospitalization insurance? ________________________________
Medicare? _______________ Medical? ________________

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 Sister needs assistance.

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____
____
____
____

Approved by Auxiliary Treasurer ____________________________________ Date ___________
Address: ____ Zip___________

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PHYSICIAN'S STATEMENT

Name and location of Hospital (if hospitalized) ______________________________________
____
Date confined from ___________________________ to ___________________________________
Diagnosis: ____
____
____
Prognosis: ____
____
Signed ____
(Physician's Signature and address)

Application granted ________ Denied ________ Date _________________ Amount $ __________

Reason if denied ____
____

This special assistance is only to be recommended for a Sister who baa been a member for at least one (1) year prior to application: that it does NOT COVER CANCER (because of the Cancer Program) That only two (2) grants are allowed per member; and that a full twelve (12) months must pass before a second request is made. The Assistance will not exceed Seven Hundred Fifty Dollars ($750.00) per hospitalization. The check will be sent to the Auxiliary Treasurer to be given to the Auxiliary Sister and if the member has passed on, the check must be returned to the Department Office.

This request must be kept confidential, and the Auxiliary must, to the best of *its* ability, thoroughly investigate and find that this Auxiliary Sister does qualify

CRITERIA FOR APPROVING MEDICAL ASSISTANCE GRANTS

1. Number of years of membership.
2. If member bas hospitalization Insurance.
3. Percentage of Hospital Bills covered by Insurance.
4. Need for Assistance
5. Physician's statement and prognosis: