For your Cancer Relief Request to be handled properly, it is important that you take the time to read the instructions and eligibility terms before completing the application.

Eligibility

1. Applicant must be a member of the Auxiliary VFW Post 7945 for one full year.
2. Surgery or treatment must occur after one full year of membership.
3. Current dues must be paid by any continuous member or rejoined member, and Life members must be current on their Cancer Relief payments at the time of application.
4. Six months must elapse between new surgery or treatment before a second application will be considered. Continuous treatment which lasts beyond the initial six-month period will qualify for a second application for relief.
5. Applications will NOT be accepted for deceased members.
6. Relief applications "in process" at the time of a member's death will be processed.

Instructions

1. Member must complete, sign and date top portion of application.
2. Physician must complete, sign and date lower portion of application.

Completed applications should be mailed to:

Pat Garcia, Chairman

11299 E 159th Pl Brighton, Co 80602

Social Security, Medicare, Medicaid, and VA Pension Recipients

Discuss with your agency and get a ruling in writing that acceptance of this grant will not jeopardize your regular benefits.

APPLICATION FOR CANCER RELIEF - AUXILIARY VFW 7945

Mail application to: Pat Garcia, Chairman – 11299 E 159th Pl, Brighton, CO 80602

Member's Full Name____

Street Address____

City_____________________State___________Zip Code____________________

Home Phone #_________________________Membership #__________________

Member's Signature___________________________Date_______________________

Next of Kin/Power of Attorney

In all cases where patient is unaware of condition, the check will be made payable to the member and mailed to the person shown as next of kin, or person holding Power of Attorney.

Name________________________________Phone #_________________________

Address________________________City_____________State_____Zip_________

The Following Must be Completed by Attending Physician

Type of Cancer diagnosed? ____

Was condition pathologically diagnosed as cancer?___Yes____No_____Date____

Will the patient receive treatment for the above cancer diagnosis?__Yes___No__

First date of treatment for this cancer_____________________________________

Attention Physician: Thank you very much for your cooperation in furnishing information pertaining to the diagnosis and treatment of cancer for our Auxiliary Member.

Physician Name____

Physician's Signature____

Address_______________________City______________State________Zip______

Date Signed____