In order 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:

Shirley Colvin, Chairman
8381 Delaware
Denver, CO 80221

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: Shirley Colvin, Chairman – 8381 Delaware, Denver, CO 80221

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 cance? 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 _____

UNWAVERING SUPPORT
FOR UNCOMMON HEROES

Application for a Cancer Grant - National

Eligibility Requirements:

- Applicant must be a member of the Auxiliary VFW for one (1) full year.
- Current dues must be paid before applying for a cancer grant.
- After twelve (12) months have passed from date of diagnosis or last treatment, application will not be accepted.
- A member is allowed two (2) grants during their lifetime. Twelve (12) months must elapse between new diagnosis and/or treatment for a second application to be considered. Continuous treatment which lasts beyond the twelve (12) month period will qualify for a second grant.
- Application will be rejected if member has been deceased for longer than thirty (30) days.

Instructions:

- Member must complete in its entirety the Member's portion of the application.
- If the member has deceased, a family member may submit this application with documentation of proof of death such as obituary, doctor's letter, etc.
- Physician must complete in its entirety the Physician's portion of the application.

Mail completed form to:

Auxiliary VFW
ATTN: Cancer Grants
406 W 34th St, Floor 10
Kansas City, MO 64111

Application for a Cancer Grant - National

This Section to be Completed by Member

Membership # _____

Member's Full Name _____

Auxiliary # _____ Date of Birth _____ Phone # _____

Street Address _____ City _____

State _____ Zip Code _____ Email Address _____

Member or Power of Attorney (attach POA document) Signature _____

Date Signed _____

This Section to be Completed by Attending Physician

Type of cancer diagnosed? _____

Date of diagnosis with this cancer? _____

Most recent 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 VFW member.

Physician Name _____ Phone No _____

Physician Signature _____ Date _____

Address _____ City _____ State _____ Zip _____