



**In order for your Cancer Grant to be handled properly,  
it is important that you take time to read the instructions and eligibility terms  
before completing the application.**

### ELIGIBILITY

1. Applicant must be a member of the Ladies Auxiliary VFW **one (1) full year**.
2. Surgery of treatment **after** one (1) full year of membership.
3. **Current dues must be paid** before applying for a cancer grant. This also applies to **reinstated members**.
4. After twelve months has passed from date of last surgery, treatment or diagnosis application will not be accepted.
5. A member is allowed *two (2)* grants during her lifetime. Twelve (12) months must elapse between new surgery 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.
6. Applications will **not** be accepted for **deceased members**.
7. Grants "in process" (**date stamped upon receipt at National Headquarters**) at the time of a member's death will be processed.

### INSTRUCTIONS

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

### **COMPLETED APPLICATIONS SHOULD BE MAILED TO**

**Ladies Auxiliary VFW  
406 W. 34<sup>th</sup> St. (10<sup>th</sup> Floor)  
Kansas City, MO 64111  
Phone No. 816-561-8655 Ext. 29**

**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 A CANCER GRANT

MAIL COMPLETED APPLICATION TO: Ladies Auxiliary VFW – 406 W. 34<sup>th</sup> St. (10<sup>th</sup> Floor) – Kansas City, MO 64111

Auxiliary No. \_\_\_\_\_ Member's Full Name \_\_\_\_\_  
(as shown on face of dues card)

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone No. (\_\_\_\_) \_\_\_\_\_ Work Phone No. (\_\_\_\_) \_\_\_\_\_

Member's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

### IF PATIENT IS UNAWARE OF CONDITION

**In all cases where the patient is unaware, the check will be made payable to the member and mailed to the person shown below as the Next of Kin, or Person holding Power of Attorney.**

Name \_\_\_\_\_ Phone No. (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**This part to be filled out by the Attending Physician**

1. Type of cancer diagnosed? \_\_\_\_\_

2. Was condition pathologically diagnosed as cancer? \_\_\_\_\_ Date \_\_\_\_\_  
(Yes) (No)

3. Was patient hospitalized for **this** cancer condition? \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
(Yes) (No) (Dates)

4. Did the patient have surgery for cancer? \_\_\_\_\_ Type of surgery: \_\_\_\_\_  
(Yes) (No)

5. Will the patient receive treatment for the above cancer diagnosis? \_\_\_\_\_  
(Yes) (No)

6. If so, what type of treatment? (Specify) \_\_\_\_\_

7. First date of treatment for **this** cancer: \_\_\_\_\_

**ATTENTION DOCTOR:** Thank you very much for your cooperation in furnishing information pertaining to the diagnosis and treatment of cancer for our Auxiliary member.

Physician's Signature \_\_\_\_\_ Phone No. (\_\_\_\_) \_\_\_\_\_

Physician's Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ (please print) City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_