APPLICATION FOR A CANCER GRANT

Eligibility Requirements:

- Applicant must be a member of the VFW Auxiliary 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 lifetime. Twelve (12) months **must** elapse between new diagnosis and/or treatment from date of first grant 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 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 death such as obituary, doctor's letter, etc.
- Physician must complete in its **entirety** the Physician's portion of the application. Supporting documentation will not be considered.
- **Mail** completed application to: **VFW AUXILIARY**
  ATTN: CANCER GRANTS
  406 W. 34TH STREET, 10TH FLOOR
  KANSAS CITY, MO 64111

This section to be filled out by the Member

Membership ID No. ________________ Member's Full Name ______________________________
(as shown on face of membership card)

Auxiliary No. ____________ Date of Birth ________________ Phone No. (_____) ________________

Street Address ____________________________________ City ____________________

State _________ Zip Code _____________ E-mail Address ______________________________

Member's **or** Power of Attorney's (attach P.O.A. document) Signature ____________________ Date Signed _________

This section to be filled out by the Attending Physician

1. Type of cancer diagnosed? ______________________________
2. Date diagnosed with **this** cancer? ______________________________
3. Most recent 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 VFW Auxiliary member.**

Physician's Signature ____________________________________ Date ____________________

Physician's Name ____________________________________ Phone No. (____) ________________
(please print)

Address ______________________________ City ________________ State _____ Zip Code ________

If cancer grant is approved, funds must be deposited within six months or grant is considered forfeited. *Revised 08/2015*