## **APPLICATION FOR A CANCER GRANT**



## **Eligibility Requirements:**

- Applicant must be a member of the Ladies 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 her lifetime. Twelve (12) months <u>must</u> 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 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 an obituary, doctor's letter, etc.
- Physician must complete in its entirety the Physician's portion of the application.
- Mail completed application to:

LADIES AUXILIARY VFW ATTN: CANCER GRANTS 406 W. 34<sup>TH</sup> STREET, 10<sup>TH</sup> FLOOR KANSAS CITY, MO 64111

Membership ID No	Member's Full Na	ame(as shown on face of membership card)
Auxiliary No	Date of Birth	Phone No. ()
Street Address		City
State Zip Co	ode E-mail Addres	ss
Member's or Power of Atto	rney (attach P.O.A. document) Signature	Date Signed
This	s section to be filled out by	0 ,
Type of cancer diag	nosed?	0 ,
<ol> <li>Type of cancer diag</li> <li>Date diagnosed with</li> </ol>	nosed?	
<ol> <li>Type of cancer diag</li> <li>Date diagnosed with</li> </ol>	nosed?  this cancer?  treatment for this cancer?  Thank you very much for your coope	
<ol> <li>Type of cancer diag</li> <li>Date diagnosed with</li> <li>Most recent date of</li> <li>ATTENTION DOCTOR:</li> </ol>	nosed?  this cancer?  treatment for this cancer?  Thank you very much for your coope	eration in furnishing information pertaining to or our Ladies Auxiliary VFW member.

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