THE AMERICAN LEGION
FAMILY HOSPITAL ASSOCIATION

Membership and Revenue ~ The Association is officially incorporated as The American Legion Family Hospital Association and all members of Minnesota American Legion Posts, American Legion Auxiliary Units, and Sons of The American Legion Squadrons are members of the association. Revenue for carrying on the work of the association consists of money received from Post, Unit, and Squadron dues, donations, and interest from investments.

Eligibility ~ All members of the association and eligible dependents, regardless of their place of residence, are eligible for benefits provided by the association, provided they have been members in good standing for 12 months prior to application for assistance.

Financial Assistance ~ Financial assistance is available to all eligible members of the association for payment of medical bills incurred for services provided by any duly licensed hospital or medical practitioner provided the need for financial assistance has been determined. *Before applying for aid, veterans should take advantage of the services offered them by the government at Veterans Hospitals. The member's dependents should make all possible use of other available medical assistance programs. The Association does not pay any bills that are less than $100.00 or over $3,000.00. If your bill exceeds $3,000.00, submit it to the Board and the Board will make the decision on how much is paid.*

Exceptions ~ The Association does not pay for transportation to and from the hospital (unless by ambulance), hotel-motel bills for anyone accompanying a patient unless an attendant is deemed necessary and authorized by the association, telephone bills incurred by the patient, personal service, dental work, eye wear, or hearing aids. The association does not give aid in the nature of a loan or pay credit card charges.

Procedure ~ The applicant should:

1. Contact the Service Officer of the local Post or the County Veterans Service Officer in their area to obtain an application blank.
2. Complete the application.
3. Provide copies of final medical bills.

PLEASE NOTE - The more complete your application is when submitted, the sooner we can process that application.

Information & Applications ~ To obtain further information contact The American Legion Department Headquarters at 1-651-291-1800 or 1-866-259-9163, The American Legion Auxiliary Department Headquarters at 651-224-7634 or 1-888-217-9598, or the Sons of The American Legion Detachment Headquarters at 1-651-291-1800 or 1-866-259-9163, as well as any County Veterans Service Office. Applications can also be downloaded from the web at http://mnlegion.org/Infor_letter_and_application.pdf.

The American Legion Family Hospital Association
20 W. 12th Street, Room 314, St. Paul, MN 55155
Telephone: 651-224-7634, Toll Free: 1-888-217-9598

APPLICATION FOR AID BY MEMBERS AND DEPENDENTS

Name of patient ____ Membership # ____________________
If a dependent, write "Dependent" here

Address ____
Street / Box No. City State Zip

Telephone _________________________ Work Telephone ____________________ Cell Phone ______________________

If a dependent, give name and relationship of member ____

Post/Unit/Squad No. __________ City ______________________________ How long have you been a member? _______

Have you previously applied to this Association for aid? ______ Do you have Medicare or other hospital insurance? ______

Give the name of your Insurance company ____

Date of birth of patient __________________________ Marital status _________________ Children - _____Yes _____No

Names and ages of member's children ____

Other Dependents ____

MEMBER'S / APPLICANT'S FINANCIAL STATUS

(If member is deceased, give financial status of person on whom applicant is dependent for support)

Are you employed _________________ If not, how long have you been unemployed _______________________________

Occupation _______________________________________ Name of your employer __________________________________

Monthly wage ________________________ Take home pay after withholding and S.S. tax deductions __________________

What other members of your family are working? _______________________ Their total monthly income _______________

How much VA pension or compensation do you receive a month? ____

What other source of income do you have? _____________________________ How much a month? _____________________

List your assets, including cash in checking and savings accounts, investments, real estate, etc. Also list your liabilities including unpaid mortgages, contracts, or other indebtedness, and show monthly repayment schedule.

Assets	**Liabilities**
Home _______________________________	Home or Rent _______________________________
Car (make & year) ____________________	Car or Truck Payment _________________________
Checking ____________________________	Credit Cards _______________________________
Savings _____________________________	Utilities ___________________________________
IRA ________________________________	Child Support ______________________________
Property ____________________________	Other ______________________________________
Other ______________________________	____
___________________________________	____

I hereby authorize the Hospital Association to negotiate my claim on my behalf with my medical provider using the above personal information.

Signed ____ Dated ____________________________