



NCOA[®]

NCOA MEDICAL FUND, INC.

The NCOA Medical Fund, Inc. was created to promote the health and welfare of dependents of noncommissioned and petty officers and, in particular, to aid such persons faced with catastrophic medical problems. The Fund provides assistance for medically-related incidental expenses either as non-repayable grants or in the form of no-interest loans.

The Board of Trustees of the Medical Fund is solely responsible for the selection of recipients for grants and loans from this fund. Comprised of active and retired noncommissioned and petty officers, the Board of Trustees serves at the request of the NCOA International Board of Directors and performs these duties without remuneration.

If active duty, a copy of latest LES statement and any other pay stubs (to include spouse's pay stubs) must accompany application. Application must also include a letter of explanation. Mail application, along with all pertinent documents (to include copies of invoices, statements, etc.) to:

**NCOA Medical Fund, Inc.
NCOA International Headquarters
P.O. Box 33790
San Antonio, Texas 78265**

Applications will be reviewed on a monthly basis without regard to race, color, creed, ethnic background, gender or age. Appeals can be made only to the Board of Trustees of the NCOA Medical Fund.

The NCOA Medical Fund Board of Trustees recognizes and appreciates the dedication of the NCOA Board of Directors, the International Staff, and most of all ... the members of our great Association who caused this dream to become a reality.

NCOA Medical Fund Grant Application

Personal Information

Service Member _____ Rank _____

Social Security # _____ Branch _____ Status _____

Address _____

City _____ State _____ Zip _____

Telephone - Work (_____) _____ Home (_____) _____

Patient _____ Sex _____

Date of Birth _____ Relationship to Service Member _____

Other individuals in household:

| Name | Age | Relationship |
|-------|-------|--------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Medical Information

Patient's diagnosis _____

Date of diagnosis _____ Physician's phone _____

Patient's physician _____

Physician's address _____

You must include a signed statement from the physician in charge as to the recommended treatment for the applicant.

Medical Facility

Name _____

Address _____

City _____ State _____ Zip _____

Anticipated date of treatment _____

Financial Information

TOTAL monthly income - Amount _____ Source _____
(Gross - submit pay voucher)

Amount _____ Source _____
(Gross - submit pay voucher)

Amount _____ Source _____
(Gross - submit pay voucher)

Total monthly expenses _____

Please list insurance companies (CHAMPUS, Medicare, civilian) _____

Anticipated insurance coverage of treatment _____ %

Total grant/loan request \$ _____

| List other financial resources - | Amount | Date |
|----------------------------------|--------|-------|
| Air Force Aid | _____ | _____ |
| Navy Relief Society | _____ | _____ |
| Army Emergency Relief | _____ | _____ |
| Red Cross | _____ | _____ |
| Church | _____ | _____ |
| Community Fund Raising | _____ | _____ |
| Loans | _____ | _____ |
| Other _____ | _____ | _____ |
| <small>(Specify source)</small> | | |

List special medically-related ancillary expenses (use additional sheet if necessary)

| | | | |
|-----------|----------|---------------------------------|----------|
| Lodging | \$ _____ | Transportation | \$ _____ |
| Food | \$ _____ | Other _____ | \$ _____ |
| Utilities | \$ _____ | <small>(Please specify)</small> | |
| | | TOTAL | \$ _____ |

Comments _____

I certify that I have made reasonable efforts to contact and solicit help from all available resources prior to applying for a NCOA Medical Fund Grant, and that the information provided on the application is complete, true and correct.

Service Member's signature _____ Date _____