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. Copies of final medical bills must be provided.

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.

Board of Trustees

President	Dean Knutson 15389 Cty Rd 26, Dalton, 56324 218-747-2724	Trustee	Michael Neubarth 163 Fernberg Rd, Ely,55731 218-365-6441
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* The Department Commander, Department President and Detachment Commander are members of the Board.

The American Legion Family Hospital Association
20 W. 12th Street, Room 300A, St. Paul, MN 55155
Telephone: 651-291-1800, Toll Free: 1-866-259-9163

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

Home _____
Car (make & year) _____
Checking _____
Savings _____
IRA _____
Property _____
Other _____
_____

Liabilities

Home or Rent _____
Car or Truck Payment _____
Credit Cards _____
Utilities _____
Child Support _____
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 _____