



ALAMO CHAPTER 5
Rolling Oaks Baptist Church
6401 Wenzel Road
San Antonio, TX 78233
<https://davalamo5.org>

17 August 2024

Subject: V.G. Clark Cancer Relief Fund Outreach

Fellow Veteran Organization,

Greetings from DAV Alamo 5. We are writing to solicit your help in providing eligible veterans with financial assistance in their time of need. One of our founding members has blessed our organization with a trust fund to assist veterans who are being treated for cancer and in financial hardship with a small token of financial assistance, up to \$250/veteran/month for a maximum of six (6) months.

We need your help in identifying veterans within your community who might need this assistance. The veteran does not need to be a DAV member to qualify for this assistance. The criteria are threefold: being a veteran, currently receiving treatment for cancer, and experiencing financial hardship. All three criteria must be validated with documents. For example, a valid military or veteran administration ID card or DD214; current appointment letter from inpatient or outpatient clinic, and delinquent bill or explanation of financial hardship. DAV Alamo 5 has a committee which will evaluate each request. The process is simple. We have attached a document for your convenience. The veteran should send all requests and validating documentation to DAV Alamo 5 email, dav.alamo5sa@gmail.com. Please include in the email Subject Line: V.G. Clark Cancer Relief Fund Request.

We thank you in advance for your assistance.

Kathleen Kaberides
Kathleen Kaberides
Commander
DAV Alamo Chapter 5



**DISABLED AMERICAN VETERANS
ALAMO CHAPTER 5
6401 WENZEL ROAD
San Antonio, TX 78233**



**V.G. CLARK CANCER RELIEF TRUST FUND
REFERRAL FORM**

ARE YOU A DAV ALAMO 5 MEMBER (not required for assistance): YES NO

VETERAN'S NAME: _____

VETERAN'S ADDRESS: _____

VETERAN'S PHONE # _____ EMAIL ADDRESS _____

SUPPORTING DOCUMENT AS A VETERAN: _____ MILITARY ID _____ VETERAN ID _____ DD 214 _____ VA LETTER

CANCER DIAGNOSIS: YES _____ (type) _____ ACTIVE TREATMENT: YES NO

INPATIENT/OUTPATIENT TREATMENT FACILITY:

_____ Treatment Facility Name, Address, City, State, Zip code

_____ Last treatment date: _____ Next treatment date: _____
Facility Phone number

FINANCIAL NEED: YES NO

DESCRIBE FINANCIAL HARDSHIP AND PROVIDE DOCUMENTATION, IF NECESSARY:

VETERAN'S SIGNATURE: _____ DATE: _____

I verify that the above information is true and correct. If found to be not true or accurate, I will reimburse DAV Alamo 5 all payments made to me or on my behalf.