



Application for Participant Fee Scholarship

The Physicians' Health Programs has established this assistance for those physicians or other medical professionals who cannot afford the monthly participant fees. Each applicant **must demonstrate financial need** by properly completing an Application for Scholarship Assistance (PLEASE PRINT). Also required is a copy of the applicant's most recent federal income tax return—personal and business, if applicable. **An incomplete application will be returned for proper completion.**

Please note that the penalty for submission of fraudulent information will be immediate cessation of assistance.

Assistance is provided for a limited time. If additional assistance is needed, another application will need to be completed.

If you have any questions, contact the PHP at (866) 747-2255, Monday through Thursday, from 7:30 a.m. to 5:00 p.m.

SECTION ONE –PLEASE PRINT Applicant Information:

Applicant's Name: _____

Address: _____ Date of Birth: _____

_____ Home Telephone #: _____

_____ Work Telephone #: _____

County: _____ Social Security #: _____

Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widow/Widower

Occupation: _____ Specialty: _____

Employer's Name: _____

Address: _____ Employer's Telephone #: _____

(If more than one employer, list the above employment information on a separate sheet of paper and attach list to application.)

Dependent/Nondependent Information

Number of Dependents: _____ (If more than zero (0), please specify below.)

Number of Children who are not dependents: _____ (If more than zero (0), please specify below.)

| | Name/Address/Telephone | Relationship to Applicant | Date of Birth | Social Sec. # | "X" If A Dependent |
|---|------------------------|---------------------------|---------------|---------------|--------------------|
| 1 | | | | | |
| | | | | | |
| | Phone: | | | | |
| | | | | | |
| 2 | | | | | |
| | | | | | |
| | Phone: | | | | |
| | | | | | |
| 3 | | | | | |
| | | | | | |
| | Phone: | | | | |
| | | | | | |
| 4 | | | | | |
| | | | | | |
| | Phone | | | | |

List additional dependent/nondependent information on a separate sheet and attach to application.

SECTION TWO -- INCOME:

A. List wages, salaries, etc. (Round all amounts to nearest dollar.)

| | Employer's Name | Yearly Amount | Monthly Amount |
|---|------------------------|----------------------|-----------------------|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| | TOTAL | | |

B. List pension, social security, Medicare, Medicaid, insurance, or other regular assistance—either private or government sources:

| | Source | Type | Yearly Amount | Monthly Amount |
|---|---------------|-------------|----------------------|-----------------------|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| | TOTAL | | | |

C. List interest, dividends, capital gains, and other investment income:

| | Source | Yearly Amount | Monthly Amount |
|---|---------------|----------------------|-----------------------|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| | TOTAL | | |

D. List parent's/children's contributions to support applicant:

| | Name | Yearly Amount | Monthly Amount |
|---|--------------|----------------------|-----------------------|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| | TOTAL | | |

E. List other possible sources of assistance:

| | Name | Yearly Amount | Monthly Amount |
|---|---|----------------------|-----------------------|
| 1 | Relatives (other than parents/children) | | |
| 2 | Friends | | |
| 3 | Fraternal Organizations | | |
| 4 | Asset Sales | | |
| 5 | Other, (specify) | | |
| | TOTAL | | |

TOTAL INCOME OF APPLICANT
FROM ALL SOURCES

=====

SECTION THREE -- MONTHLY EXPENSES:

PERSONAL

Rent/Home Mortgage \$ _____

Utilities (telephone, electric, heat, etc.) \$ _____

Food/Household Supplies \$ _____

Clothing \$ _____

Medical/Dental (not insurance premium) \$ _____

Essential Medication \$ _____

Insurance Premiums

Life \$ _____

Property/Homeowner \$ _____

Automobile \$ _____

Health \$ _____

Disability \$ _____

Total Insurance Premiums \$ _____

Taxes

Personal \$ _____

Property \$ _____

Other \$ _____

Total Taxes \$ _____

Dependent Care \$ _____

Institution Costs \$ _____

Therapy Costs \$ _____

Toxicology Screens \$ _____

Vehicle Payments \$ _____

Debt Repayment (loans) \$ _____

Credit Cards, Please Specify: _____

_____ \$ _____

_____ \$ _____

Other, Please Specify: _____ \$ _____

TOTAL PERSONAL EXPENSES PER MONTH \$ _____

BUSINESS (If applicant does not own a business, it is not necessary to complete the monthly business expense section.)

Rent/Mortgage \$ _____

Utilities (telephone, electric, heat, etc.) \$ _____

Staff Salaries/Benefits \$ _____

Supplies \$ _____

Equipment Lease \$ _____

Insurance Premiums, Please Specify: _____
_____ \$ _____

Other, Please Specify: _____
_____ \$ _____

TOTAL BUSINESS EXPENSES PER MONTH: \$ _____

TOTAL MONTHLY INCOME (Section Two): \$ _____

TOTAL MONTHLY EXPENSES (Section Three): \$ _____

TOTAL MONTHLY NET INCOME/LOSS
(subtract expenses from income) \$ _____

SECTION FOUR – ASSETS:

List market value of all assets owned, including those on which you have outstanding loan balances
(for example real estate, home mortgage, vehicles, auto loans):

Real Estate \$ _____

Stocks \$ _____

Bonds \$ _____

Life Insurance \$ _____

Savings Accounts \$ _____