Physicians' HEALTH Program

The Foundation of the Pennsylvania Medical Society

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

Item		Amount
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 $____________________

Checking Accounts $____________________

Cash $____________________

Vehicles $____________________

Other, Please Specify $____________________

TOTAL ASSETS **$**____________________

SECTION FIVE – LIABILITIES

List outstanding balance of all liabilities:

Home Mortgage	$____________________
Auto Loan	$____________________
Home Equity Loan	$____________________
Credit Card Debt	$____________________
Other Loans	$____________________
Other Debt or Liabilities, Please Specify:________________	$____________________
____	
TOTAL LIABILITIES	**$____________________**

SECTION SIX – GENERAL INFORMATION

I have explored and exhausted all sources of assistance; therefore, I am requesting assistance from the Scholarship Fund.

I certify that the information on this application is correct and complete to the best of my knowledge and belief and that I have explored and exhausted all sources of assistance. I grant the Physicians' Health Programs the authority to verify any of the information provided and authorize the employer(s) and any lender listed on this application to release to the PHP all other date requested to meet its requirements and guidelines.

Signature of Applicant:____

Date: ____