



Physicians'
HEALTH
Program

The Foundation of the Pennsylvania Medical Society
777 East Park Drive
PO Box 8820
Harrisburg, PA 17105-8820

Application for Participant Fee Scholarship

The Physicians' Health Program 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.

Please mail your completed scholarship application to the PHP at the above address or fax it to (855) 933-2605.

If you have any questions, contact the PHP at (717) 558-7819, 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	\$ _____
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 Program 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 data requested to meet its requirements and guidelines.

Signature of Applicant: _____

Date: _____