



TEXAS MEDICAL
ASSOCIATION

The Physicians Benevolent Fund
Physicians Caring for Texans

TMA PHYSICIANS BENEVOLENT FUND (PBF) CONFIDENTIAL APPLICATION

The Physicians Benevolent Fund provides temporary assistance to physicians and their immediate families in need. The late May Owen, MD, a Fort Worth pathologist and past president of TMA, created the Fund in 1961. Income and resource guidelines must be met. ***Failure to answer all questions or attach required documentation will delay or prevent consideration for financial assistance.***

APPLICATION PROCESS

Eligibility Criteria

- Assistance is based on information supplied on the application and during a home visit.
 - Physician must be current resident of Texas.
 - Physician must be in good standing with the Texas Medical Board.
 - Liquid asset limits may not exceed the 150% of the Health and Human Services thresholds for current year.
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Application

- ALL requested information will be used by The PBF Committee to determine eligibility for assistance.
 - The application must be legible, signed, and dated or it will be returned to you without consideration.
 - A complete application includes submission of the following items:
 - Complete and legible application;
 - Copy of last filed income tax return;
 - Copies of most current utility bills; and
 - Financial strategy plan.
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How Much Money Can a Physician Receive and for how long?

- Assistance is at the discretion of The PBF Committee.
 - Assistance shall not exceed a 6-month period without PBF Committee approval.
 - If eligible, a home visit is required.
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How do I apply?

Mail the completed application with accompanying documents to:

Texas Medical Association
The Physicians Benevolent Fund
Attn: Chris Johnson, Sr. Program Manager
401 West 15th Street
Austin, TX 78701-1680

If you have questions about the fund or how to complete the following form,
please contact Chris Johnson at 512-370-1602.

APPLICANT INFORMATION

Full Name: _____ Date of Birth: _____

Telephone: _____ Cell Phone: _____

Current Place of Residence: Own home Nursing Facility
 Adult Family Home Assisted Living Other _____

Street Address: _____

City/State/Zip: _____

Email Address: _____

Are You: Physician Spouse Dependent
 Married Divorced Single Widow

Are you a TMA member? Yes No If yes, years of membership: _____

Medical School Physician Graduated from: _____

Year: _____

Year completed Residency: _____ Specialty: _____

Current Medical Licensure status: Are You: Retired Active On Probation
 Suspended Revoked Other _____

Amount Requesting: \$ _____

DEPENDENTS

Include all family members living with you.

Name	Relationship	Age	Monthly Contribution

Family members not living with you who assist.

Name	Relationship	Profession	Monthly contribution

MEDICAL INFORMATION

Attending Physician's Name: _____ Telephone: _____

Street Address: _____

City/State/Zip: _____

Please list specific health problems, indicating the date problem first occurred.

Problem	Date

FINANCIAL INFORMATION

Are you employed? Yes No If no, are you? Retired Disabled

Current Employer : _____ Occupation: _____

Employed: Part-time Full-time

Do you handle your own affairs: Yes No

If no, who is responsible?

Name : _____ Relationship: _____

Telephone: _____

Street Address: _____

City/State/Zip: _____

Please tell us about your assets and liabilities

ASSETS		LIABILITIES	
Cash on hand & in banks	\$	Primary Home Mortgage Balance	\$
Savings accounts/CD(s)	\$	Auto 1- Loan Balance	\$
IRA(s)/401(k) or Other Retirement Accounts	\$	Auto 2- Loan Balance	\$
Stocks and Bonds	\$	Loan on Life Insurance	\$
Life Insurance-Cash Surrender Value Only (Complete Section 1)	\$	Personal Loan Balance (Describe in section 4)	\$
Automobile1-Present Value	\$	Balance on Unpaid Taxes (Describe in Section 5)	\$
Automobile2-Present Value	\$	Credit Card(s) Debt Balance (Describe in Section 6)	\$
Home Value	\$	Other Liabilities (Describe in Section 6)	\$
Other Real Estate (Describe in Section 2)	\$	_____	\$
Other Assets (Describe in Section 3)	\$	_____	\$
Total Assets:	\$	Total Liabilities:	\$

Automobile 1: Year: _____ Model: _____

Automobile 2: Year: _____ Model: _____

Section 1. Life Insurance Held. (Give face amount and name of insurance company and beneficiaries)

Section 2. Other Real Estate Owned. (List each parcel separately. Use attachment if necessary. Each attachment must be identified as part of this statement and signed)

	Property A	Property B	Property C
Type of property			
Address			
Present Market Value			
Mortgage Holder			
Amount of Payment per month			
Mortgage Balance			
Status of Mortgage			

Section 3. Other Assets (Describe in detail)

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Section 4. Personal Loans

Name of Noteholder	Original Balance	Current Balance	Payment Amount	Frequency (monthly, etc.)

Section 5. Unpaid Taxes. (Describe in detail, as to type, to whom payable, when due, amount, and to what property, if any, a tax lien attaches)

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Section 6. Credit Card Debt and Other Liabilities

Name of Noteholder	Current Balance	Payment Amount	Frequency (monthly, etc.)

Bankruptcy:

Have you ever filed for personal bankruptcy, had property you owned foreclosed, or made a settlement or an assignment for the benefit of creditors? Yes No

If yes, provides date(s) and describe in detail below.

Monthly Income

Your Wages:	\$	VA Compensation:	\$
Other Wages:	\$	Welfare Assistance:	\$
Other Wages:	\$	Medicare:	\$
Retirement Income:	\$	Health Accident Insurance:	\$
SSI Disability Income:	\$	Survivor's benefits:	\$
Social Security Income:	\$	Unemployment:	\$
Social Security Income Supplemental:	\$	Other: (<i>describe in section 1</i>)	\$
Disability Insurance Income:	\$	Total Income:	\$

Section 1: Describe other income:

Monthly Expenses

HOUSING		TRANSPORTATION	
<input type="checkbox"/> Rent	\$	Car payment#1	\$
<input type="checkbox"/> House Payment		Car payment#2	\$
Home/Renter's insurance	\$	Auto insurance premium	\$
Property taxes	\$	Fuel	\$
Maintenance & repairs	\$	Public transportation	\$
Housekeeping (supplies)	\$	Repair and maintenance	\$
Food	\$	Other:	\$
Other:	\$	MEDICAL	
UTILITIES		Medical Insurance	\$
Electricity	\$	Medical/hospital bills exceeding coverage/Copay	\$
Phone	\$	Medication expenses	\$
Water	\$	Other:	\$
Gas	\$	Other:	\$
Internet/Cable	\$	INSTALLMENT PAYMENTS (LIST)/DEBT	
Other:	\$		\$
PERSONAL CARE			\$
Clothing	\$		\$
Dry Cleaning	\$		\$
Beauty/Toiletries	\$	OTHER EXPENSES (LIST)/DEBT	
Entertainment	\$		\$
Other:	\$		\$
Other:	\$		\$
Other:	\$		\$

TOTAL MONTHLY EXPENSES:

TOTAL SURPLUS/DEFICIT:

If deficit, how do you currently meet? _____

SOURCES OF INSURANCE

Hospitalization Yes No What company? _____
Disability Yes No What company? _____
Supplemental Yes No What company? _____
Long-Term Care Ins. Yes No What company? _____

Did you or your spouse serve in the military? Yes No

Other Applicable Information that Might be Useful to the Review Committee

How did you hear about PBF?

I certify that the information provided on this application is accurate. I understand that withholding of information or giving false information will result in refusal of assistance.

Signature

Date