TEXAS MEDICAL ASSOCIATION

The Physicians Benevolent Fund
Physicians Caring for Texans

TEXAS MEDICAL ASSOCIATION
PBF WELLNESS FUND
CONFIDENTIAL APPLICATION

The Physicians Benevolent Wellness Fund assists physicians and their immediate families in need with household expenses while the physician is in treatment and not working. ***Failure to answer all questions or attach required documentation may delay or prevent consideration for financial assistance.***

APPLICATION PROCESS

Eligibility Criteria

- Assistance is based on information supplied on the application.
- Physicians must hold a valid and current Texas medical license.
- Must be a current resident of Texas.
- Currently participating in treatment for depression, substance use disorders, or other potentially impairing conditions.

Application

- ALL requested information will be used by The Physicians Benevolent Fund 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 and other documentation supporting current financial need.

How Much Money Can a Physician Receive?

- The PBF Wellness fund is dependent upon donations. Generally speaking, applicants could receive assistance for 6 months based on their application.
- Assistance is non-renewable.
- All approved proceeds are payable directly to creditors.

How Do I Apply?

Mail the completed application with accompanying documents to:

Texas Medical Association
PBF Wellness Fund
Attn: Chris Johnson, Director
401 West 15th Street
Austin, TX 78701-1680

Call (512) 370-1602 if you want to send via secure encrypted email.

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

PBF WELLNESS FUND CONFIDENTIAL APPLICATION

Reset Form

A. Request for Assistance

Name of physician making request: _____

Address: _____

_____

_____

Telephone Number: _____ _____

Home Mobile

Date of Birth: _____

Amount requested $ _____

B. Current Employment Status

☐ Employed ☐ Unemployed

If employed,

☐ Part-time ☐ Full-time

Where: _____

Length of employment: _____

Leave of Absence? ☐ Yes ☐ No

If Yes…….Begin date: _____ End date: _____

If unemployed,

How long have you been unemployed? _____

How long do you anticipate being unemployed? _____

Previous employment (for past 5 years)

Where	Duration
_____	_____
_____	_____
_____	_____

C. Educational Background

Medical school graduated from: _____

Year graduated: _____

Residency program(s) attended:

Program Name	Years
_____	_____
_____	_____
_____	_____

Year completed residency: _____

D. Current Texas Medical Licensure Status – Requires a current valid license

☐ Retired ☐ On probation

☐ Active ☐ Suspended ☐ Revoked

☐ Other _____

Length of time at the current status: _____

E. Family History/Household Status

Total number of people living in your household: _____

Current relationship status

☐ Single (never married) ☐ Divorced ☐ Separated

☐ Married ☐ Widow/Widower

☐ In a relationship

Number of children: _____

Number of children in household: _____

Ages of children receiving financial support: _____

_____

_____

_____

F. Monthly Sources of Income and Amount: ***(Identify income from any of the following sources, including periodic payments.)***

List all income in your household:	PHYSICIAN	SPOUSE	OTHER
Earnings/wages	$	$	$
Interest/dividend income	$	$	$
Retirement income	$	$	$
Disability income	$	$	$
Social Security income	$	$	$
Social Security income supplement	$	$	$
Unemployment compensation	$	$	$
Welfare assistance	$	$	$
Medicare	$	$	$
Health accident insurance benefits	$	$	$
Survivor's benefits	$	$	$
Veteran's compensation	$	$	$
Familial Support (identify below)	$	$	$
Alimony	$	$	$
Other (explain):	$	$	$
TOTAL	$	$	$

Other pertinent financial information: _____

_____

_____

_____

_____

G. Monthly Expenses: (Provide average monthly expense details.)

HOUSING		TRANSPORTATION	
☐ Rent or ☐ House Payment	$	Car payment#1	$
Home insurance	$	Vehicle (year and model)	
Property taxes	$	Car payment#2	$
Maintenance & repairs	$	Vehicle (year and model)	
Housekeeping (supplies)	$	Auto insurance premium	$
Other: _____	$	Fuel	$
UTILITIES		Public transportation	$
Electricity	$	Repair and maintenance	$
Phone	$	**MEDICAL**	
Water	$	Medical Insurance	$
Gas	$	Medical/hospital bills exceeding coverage/Copay	$
Internet	$	Medication expenses:	$
Other:_____	$	Other: _____	$
PERSONAL CARE		Other: _____	$
Clothing	$	**INSTALLMENT PAYMENTS (LIST)**	
Dry Cleaning	$		$
Personal Toiletries	$		$
Entertainment	$		$
Other: _____	$		$
Other: _____	$	**OTHER EXPENSES (LIST)**	
Other: _____	$		$
Other: _____	$		$

TOTAL: $ 0

H. Sources of Insurance

Hospitalization	☐ Yes	☐ No	What company?	_____
Disability	☐ Yes	☐ No	What company?	_____
Overhead Expense	☐ Yes	☐ No	What company?	_____

Other: _____

I. Other Applicable Information that Might be Useful to the Review Committee

J. How did you hear about the PBF Wellness Fund?

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.

Signed: _____
Physician Applicant

Date: _____