



**515 Madison Avenue, Fl. 8
New York, NY 10022
646-908-2637**

**staff@physicianshome.org
www.physicianshome.org**

Dear Friend,

Thank you for inquiring about Physicians' Home. Enclosed is an application for assistance. Please note the basic eligibility requirements, i.e., having obtained a license to practice medicine in New York State (a Resident in training may be an exception), and having practiced in the State; physician and spouse are considered eligible based on individual circumstances. Assistance is usually in the form of modest financial support.

Please provide enough supporting information so that we have a good picture of your financial need, assets, and associated circumstances. If your situation involves a dependency problem of any type, provide a note from your treating physician or rehabilitation program saying that you are participating in appropriate care is required. The general guideline is for us to help individuals in need to meet basic living requirements.

Please remember to bring the second page of the application to a notary for signature verification. If circumstances make this difficult, e.g. a debilitating illness, you may inform us of such.

New applications are reviewed at regular intervals, so you may hear from us within four to six weeks after the application is received.

Sincerely,

Physicians' Home

Physicians' Home

515 Madison Ave., FL 8
New York, NY 10022

Tel: (646) 908-2637
Fax: (646) 908-3982

Email: staff@physicianshome.org

Physician Application for beneficiary assistance --

Please note: Having obtained a NY State Medical license, and having practiced in NY State, are requirements for assistance; a Resident in training may be an exception to the license rule.

1. Name: _____ Age: _____ Date of birth: _____
2. Citizenship: [☐] USA [☐] Other: _____ Tel. #: _____
3. Address: (include apt. # and zip code):

4. Email address: _____
5. Are you living by yourself, with family, or friend, or in a group Residence: _____
6. If you can, please provide name & tel # for a contact person (family, friend, colleague) in the event you cannot be reached: _____

7. How you heard about Physicians' Home? _____
8. Medical School & Yr. of Graduation: _____
9. Have you obtained a License to practice Medicine in NY State: [☐] Yes [☐] No
License #, if you can provide it: _____
10. Have you ever been convicted and served jail time? [☐] Yes [☐] No
If yes, explain the charges committed of any crime and/or how long it was served.

11. Please indicate your field and the approximate dates during which you practiced in NY State:

12. If you have been a member of any Medical Societies, such as State, County, or Specialty Societies, please list: _____

13. On a separate sheet, please provide the following:

- a) Describe the circumstances that prompt you to seek assistance from Physicians' Home –
- b) Current income each month; for example, social security, salary, pension, disability, int. & dividends; list the income of each person (s) with whom you share your residence;
- c) List assets, and state (or estimate) their value; for example, real estate, stocks/bonds, bnk. accts.
- d) List current monthly expenses; for example, rent (or mortgage) utilities, food, medicines;
- e) Indicate the amount of monthly assistance you feel you need.

14. Copy of the last income tax, Form 1040, is helpful, and in most cases is needed to help clarify the financial picture, if not submitted with application, it may be requested.

The submitted information is complete and accurate to the best of my knowledge and ability.

I understand the organization may seek to verify the information provided, and I authorize the organization to do so.

I acknowledge that Physicians' Home is formed for charitable purposes, that all decisions on applications are made at the discretion of Physicians' Home and its Board of Directors upon review of all information submitted, and that Physicians' Home will periodically re-evaluate all applicants in light of updated applicant information. Physicians' Home reserves the right to amend, withhold or discontinue beneficiary support at our discretion at any time.

Applicant signature _____ **Date:** _____

Signature Verification

ss.: On the _____ day of _____ in the year _____ before me,
the undersigned (applicant's signature above), personally appeared

_____,
personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this instrument and acknowledged to me that he/she executed the same in his/her capacity, that by his/her signature on this instrument, the individual executed this instrument, and that such individual made such appearance before the undersigned in City of _____,
State of _____.

Notary signature and stamp _____