Unforeseen occurrences can befall us all. One never knows when an unexpected turn of events can affect your loved ones, family, friends or even yourself.

Physicians who feel they may qualify for temporary assistance are encouraged to contact PAA at (310) 427-7892, or at lapaa@lapaa.org This e-mail address is being protected from spambots. You need JavaScript enabled to view it for additional information and an application or you can download the application.

Qualifications and Requirements:

* Qualified applicants must be experiencing an unanticipated and temporary significant need.
* Physicians must have worked in Los Angeles County for more than one year accumulatively.
* Physicians in training must apply for assistance through their school's financial assistance office.

All Applications must be accompanied with:

- One-Two Page Narrative outlining **1**. The hardship, **2**. How it came to be **3**. Length of anticipated need for assistance **4**. Specifically, what assistance are you are asking for.
- Applicants' most recent tax return
- Bank statement
- Curriculum vitae.
- Any other supporting documentation.

Some examples of what we fund:

* Rent or Mortgage
* Food
* Utilities
* Transportation

Some examples of what we do not fund:

* Legal Bills or Attorney Fees
* Credit Card Bills
* Business Investments
* Continuing Education

Applications are reviewed and considered by the Benevolence Chair and the Benevolence committee. **Each situation is unique; therefore, Physicians Aid Association reserves the right to request additional documentation for review and consideration.**

All applicants are treated with dignity and respect and our application evaluation process is compassionate and confidential.

PAA also encourages any physician concerned about a colleague to contact PAA; however, the potential recipient will need to complete the application and provide supporting documentation.

Physicians Aid Association
1049 Havenhurst Drive #90
West Hollywood, CA 90046
www.LAPAA.org
310-427-7892 – Fax 815-301-8601

Physicians Aid Association
Est. 1937

APPLICATION FOR FINANCIAL ASSISTANCE ___ / ___ / _____
(Date filled out)

Please complete this application legibly and in full. All supporting documentation must be received for your request to be considered.

Applicant's Name: _____

Name and Relationship of Qualifying M.D. _____
(If you are not a medical doctor, please fill in the above line)

Residence Address _____ Email _____
(Please do not use a P.O. Box, Private Mail Box, c/o Address etc.

Phone (____) ____ - _____ Fax (____) ____ - _____ Social Security # ____ - ___ - _____

Medicare # _____ Medi-Cal # _____ Date of Birth ___ / ___ / _____

Driver's License Number and State _____ Marital Status _____

M.D.'s License Number _____ Years in Practice ___ Specialty _____

Is this Medical License current and in good standing? : _____

Dates and Locations of Practice ***(Please include a copy of your Curriculum Vitae)***

Medical Society Memberships _____

Person to Notify in an Emergency _____Relationship _____

Phone (____) ____ - _____ Address _____

Please List Close Family Members, their Relationship and Address

_____ _____ _____

_____ _____ _____

_____ _____ _____

How did you hear about Physicians Aid Association?

_____

Have you previously received help from P.A.A.? _____

If so, when? _____

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/

PHYSICIANS AI/ ASSOCIATION
APPLICATION FOR FINANCIAL ASSISTANCE (continued ... Page 2)
Please use a separate sheet of paper if needed.

MONTHLY INCOME: (DOLLAR AMOUNTS)

Social Security _____

Pensions_____

Salaries_____

Disability Income_____

Family Assistance_____

Other_____
(Receipts from other sources in the last 6 months)

TOTAL INCOME_____

EQUITY: (DOLLAR AMOUNTS)
(Net of any mortgages and other loans)

Property _____
_____

Insurance Policies _____

Stocks, Bonds etc._____

Bank Accounts_____

Other _____

TOTAL EQUITY_____

MONTHLY EXPENSE: (DOLLAR AMOUNTS)

Rent/Mortgage _____
(Circle one only)
Phone/Cable/Internet _____
Food _____
Medicines _____
Clothing/Entertainment _____
Utilities_____

Auto Expense _____
Insurances _____
Other _____
Other _____
Other _____
_____

TOTAL EXPENSES_____

Accurate Monthly Income & Expense, along with Equity, are important to determine eligibility.

***** Please include a narrative (Maximum of 2 pages) explaining the events leading to your current situation and specific ways that Physicians Aid Association can be of assistance to you.**

Applications must also be accompanied by: 1. The most recent year's tax return and 2. 2 months of complete bank statement and 3. Updated and Current Curriculum Vitae.

Physicians Aid Association has the right to request at their discretion, additional information to verify applicants eligibility.

Mail, email or Fax to:
Physicians Aid Association
1049 Havenhurst Drive # 90
West Hollywood, CA 90046

Contact: Sunnie Rose, Executive Secretary
Phone: (310) 427-7892
Fax: (815) 301-8601
Email: Sunnie@lapaa.org