



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.

Pilot Program Serving Medical Residents

Residents who feel they may qualify for temporary, short-term assistance are encouraged to contact PAA at (310) 427-7892, or at lapaa@lapaa.org

Qualifications and Requirements:

- Qualified applicants must be experiencing an unanticipated and temporary significant need.
- Must have completed a minimum of one year of a Residency within LA County and are currently still in residency in Los Angeles County.

All Completed Application forms 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 you are asking assistance for.
- Applicants' most recent year's tax return
- 2 months of Bank statements
- Curriculum vitae
- Any other supporting documentation (receipts or estimates)
- Letter of good standing and verification of one year of Los Angeles County Service from designated Program Officer or Director.

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
- * School Loans

Applications are reviewed and considered by the Benevolence Chair and 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



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 AID 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