North Carolina Medical Society FOUNDATION
Opening Doors to Quality Health Care

Disaster Relief Program Application

Current Disaster: Hurricane Florence

Application and Assistance is Confidential

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

I. APPLICANT INFORMATION:

Applicant Name: _____
(Last) (First) (Middle Initial)

Please check appropriate credentials: _____MD _____DO _____PA

North Carolina Medical License #: _____

Home Street Address: _____

Home City, State, Zip: _____

Please provide BEST contact information to reach applicant directly regarding application questions and status:

Telephone/Cell: _____ Email: _____

II. MEDICAL PRACTICE INFORMATION:

Name of Medical Practice: _____

Street Address: _____

City, State, Zip: _____ Telephone (practice):_____

Fax (practice):_____ Website (if applicable):_____

Practice Tax ID #:_____

Are you currently receiving US Postal Service mail at the practice? _____Yes _____No

Please provide temporary medical practice information, if different from above:

Street Address: _____

City, State, Zip: _____

Practice Premises Are:

_____ Owned _____ Rented/Leased Monthly Payment $_____

If not owned, name of Landlord or Property Manager:_____

Practice Structure:

Independent = not hospital/health system
Solo = 1 practitioner-one owner in this practice
Examples of Multi-Group Corporations include: Mednax, EmergeOrtho, OrthoCarolina

_____ Independent Solo Practice _____Independent Group Practice

_____ System Owned Solo Practice _____ System Owned Group Practice

_____ System Affiliated Solo Practice _____ System Affiliated Group Practice

_____ Multi-Group Corporation

_____ Free/Reduced Cost Clinic Other: _____

Number of Physicians in Practice: _____ Number of Physician Assistants in Practice: _____

Number of Non-Physician/Non-PA Staff (Pre-Disaster): _____

Please provide a roster of all physicians and PAs in your practice, including yourself, who plan to return to practice in the affected area and will benefit from this assistance. Please include: Name, Professional Designation (MD, DO, PA), Home Address, NC Medical License Number and Practice Specialty.

III. DESCRIPTION OF NEEDS

Briefly describe the nature and date of the disaster and provide details on the property damage sustained (*attach additional sheet if necessary*).

_____

_____

_____

_____

Briefly describe how you plan to use NCMSF Disaster Relief funds (*attach additional sheet if necessary*).

_____

_____

_____

_____

Do you have insurance coverage for your practice facility? Yes _____ No _____
What is the deductible of your insurance policy that will provide coverage toward damages associated with this disaster? $_____

Excluding deductible, what is the net business property loss after insurance coverage? $_____

Name, address, and telephone number of insurance company:

_____

_____

Do you have any other type of insurance to cover your losses? Yes _____ No _____

What should we know about your insurance coverage and claim status?

_____

_____

_____

_____

Please describe briefly other disaster relief assistance, if any, you have already obtained or are seeking to use in restoring or rebuilding your medical practice (provide name of agency and anticipated or received amount or value of assistance)

_____

_____

_____

_____

Please provide any other information which you feel is pertinent to understanding your assistance application.

_____

_____

_____

_____

SUBMIT ALONG WITH THIS APPLICATION:

1. Roster of Physicians & PAs
2. Certification by Applicant (see next page)
3. A copy of your recently filed Insurance Claim Form
4. Photos of damages (maximum of 10)

Only one application per practice will be accepted. A physician or physician assistant owning more than one medical practice location may apply for each affected location

Financial awards are based on needs and determined at the sole discretion of the NCMS Foundation Board of Trustees. Financial awards generally will not exceed $10,000 per practice.

Apply as soon as possible - funds are limited!

Applications may also be downloaded at www.ncmedsoc.org/disasterrelief

For questions or additional information call the NCMS Solutions Center at 919-833-3836 or 800-722-1350

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CERTIFICATION BY APPLICANT

I certify that I have suffered damage to my medical practice and that the information contained in this application is true and complete.

I hereby request and authorize agents of the North Carolina Medical Society Foundation Disaster Relief Program to review all appropriate documentation that is deemed necessary in connection with my application for assistance.

I understand that submission of an application for assistance is not an entitlement and that the Board of Trustees of the North Carolina Medical Society Foundation shall have sole discretion in determining whether I receive assistance.

Signed_____ Date_____
(Please include your professional credentials)

Print Name _____

Please submit completed and signed application, as well as additional information requested to:

MAIL
DISASTER RELIEF PROGRAM
NORTH CAROLINA MEDICAL SOCIETY FOUNDATION
PO BOX 27167
RALEIGH, NORTH CAROLINA 27601

FAX
919-833-2023

EMAIL
bmckoy@ncmedsoc.org