



Ladies Auxiliary to the Maryland State Firemen's Association

Instructions for Bessie Marshall Benefit Fund

Section 1- Any member of a company or department in good standing in the Maryland State Firemen's Association who is sick or injured (**NOT IN THE LINE OF DUTY OR DEATH BENEFIT**) and thereby incapacitated may be entitled to weekly benefits. **MEMBERS MUST BE 18 YEARS OF AGE OR OLDER.** Approval will depend on compliance with the application requirements. Any sick or injured member receiving Social Security Benefits or retirement may be eligible for said benefits. All decisions regarding benefits shall be made by the Bessie Marshall Benefit committee, whose judgments in all cases shall be final and binding.

Section 2- Should sickness or injury continue for longer than one (1) week, for each week after the first week said member may be eligible to receive up to **ONE HUNDRED SEVENTY DOLLARS (\$170.00) per week not to exceed SIX (6) WEEKS OR ONE THOUSAND TWENTY DOLLARS (\$1020.00)** in any fiscal year. A member is not eligible for more than two (2) consecutive years. Any additional request for benefits must be based on a new incident, not on an existing one.

Section 3- **IMPORTANT:** No payment will be considered by the Benefit Fund Committee until all (3) three forms (A, B and C) are completely filled out and signed.

Form A MEMBER INFORMATION/NOTARY SECTION is to be filled out, signed by member, or family member if member is unable. A state certified Notary Public must be used.

Form B DEPARTMENT CERTIFICATION FOR BENEFITS to be filled out and signed by the **Company President, Chief and Secretary** and must include the company seal/stamp.

Form C MEDICAL RELEASE FORM: may only be authorized by following medical staff: **Doctor/CRNP/CNP/NP**, must include their printed name, address, phone number and medical license number.

Please note it could take up to 30-60 days to process the request.

Section 4- **BENEFITS WILL NOT BE PAID FOR PREGNANCIES OR ANY ILLNESS RELATED TO PREGNANCY.**

Section 5- **THE INFORMATION ENCLOSED IN THIS APPLICATION WILL NOT IN ANY WAY BE SHARED OR PROMOTED FOR THE PROGRAM. THIS WILL ENSURE THAT ALL REQUIREMENTS OF HIPAA - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, A 1996 FEDERAL LAW WILL BE FOLLOWED.**

Section 6- **ALL APPLICATIONS TO RECEIVE BENEFITS FROM THE BESSIE MARSHALL FUND, MUST BE SUBMITTED WITHIN NINETY (90) DAYS FROM THE RETURN TO WORK DATE LISTED ON THE DOCTORS CERTIFICATION (FORM C). ALL OTHERS WILL BE DENIED.**

Please forward completed forms to:

Bessie Marshall Benefit Fund Co-Chair
Teresa Ann Crisman 104 Ivy Lane, Greenbelt, Maryland 20770
EMAIL: tacrisman@hotmail.com Contact Phone: 240-882-6772

Supporting the needs of MSFA members who are ill or injured, not in the line of duty.

NOTE TO MEMBER REQUESTING BENEFITS:

- **FORMS (A, B, and C)** must be completed and signed by the member, in the event the member is physically unable to execute this form, it may be executed on member's behalf by an immediate family member.
 - A. FORM A – Fillable Form has been created. Please try to use this option when filling out the information. There are several sections requiring additional information: those fields have been clarified to receive additional information.
 - B. Please note that the FORM A – Application can still be printed out and completed.
- **FORMS (A, B and C)** will be submitted via US Mail to the Co-Chairman of the Bessie Marshall Benefit Fund for processing. **ALL FORMS MUST BE LIVE SIGNATURES – NO COPIES.**
- **NOTARY SECTION:** must be completed by a Notary Public. If you are in need of a notary please visit notary section for each of the surrounding states:
 - **Maryland** - [Search Notary Database \(site.com\)](#)
 - **District of Columbia** [Notary Commissions | os \(dc.gov\)](#)
 - **Virginia** [Secretary of the Commonwealth - Notary Commissions \(virginia.gov\)](#)
 - **West Virginia** [WV SOS - Business and Licensing - Notaries - Online Data Services](#)
 - **Delaware** [Delaware Notary Public - State of Delaware -](#)
 - **Pennsylvania** [Home \(pa.gov\)](#)
- **ELIGIBILITY:** The MEMBER must be over the age of 18.
- **BENEFIT SUPPORT:** The Bessie Marshall Benefit Fund is not a **LINE OF DUTY INJURY OR DEATH BENEFIT** it is for illness outside of the Fire/EMS settings.
- **BENEFIT CYCLE:** The Bessie Marshall Benefit Fund is based on a FISCAL year not a CALENDAR year - July to June.

MEDICAL CLEARANCE INFORMATION: Only the following medical staff may sign off on the application.

- A. MD - MEDICAL DOCTOR
- B. CRNP – CERTIFIED REGISTERED NURSE PRACTITIONER
- C. CNP – CERTIFIED NURSE PRACTITIONER
- D. NP – NURSE PRACTITIONER

FORM A – MEMBER INFORMATION

Please note that the fields for additional information will expand as you enter the comments.

I HEREBY REQUEST BENEFITS UNDER THE RULES SET FORTH BY THE BESSIE MARSHALL BENEFIT COMMITTEE-LADIES AUXILIARY OF THE MARYLAND STATE FIREMEN’S ASSOCIATION.

PLEASE ENTER YOUR INFORMATION – NOTE THAT THIS IS A FILLABLE FORM – FIELDS WILL EXPAND AS YOU ENTER YOUR DATA.

MEMBER INFORMATION

NAME OF MEMBER:

STREET OR P.O. BOX ADDRESS:

CITY:

STATE:

ZIP CODE:

CONTACT EMAIL:

COUNTY – DEPARTMENT LOCATION:

CONTACT PHONE:

AGE:

DATE OF BIRTH:

SOCIAL SECURITY NUMBER:

ARE YOU EMPLOYED?

FULL TIME:

PART TIME:

RETIRED:

WHAT IS THE NATURE OF YOUR ILLNESS/INJURY? – As you enter information the field will expand.

WHAT IS THE DATE OF THE ONSET OF YOUR ILLNESS/INJURY?

WAS ILLNESS OR INJURY RECEIVED AS A RESULT OF DUTIES AS A FIRE/EMS DEPARTMENT MEMBER?

YES:

NO:

WAS ILLNESS OR INJURY RECEIVED AT WORK?

YES:

NO:

Supporting the needs of MSFA members who are ill or injured, not in the line of duty.

WERE YOU EMPLOYED AT TIME OF ILLNESS OR INJURY?	<input type="checkbox"/>	YES:	<input type="checkbox"/>	NO:
IF EMPLOYED ARE YOU RECEIVING YOUR SALARY OR ANY OTHER INCOME?	<input type="checkbox"/>	YES:	<input type="checkbox"/>	NO:
ARE YOU COVERED BY ANY TYPE OF COMPENSATION?	<input type="text"/>			
(I.E. HEALTH INSURANCE, ACCIDENT, WORKERS COMPENSATION)	YES:	<input type="checkbox"/>	NO:	<input type="checkbox"/>
IF YES, PLEASE EXPLAIN: – As you enter information the field will expand.				
<input type="text"/>				
EXPLAIN HOW YOU WILL USE THESE FUNDS TO FULFILL YOUR NEEDS: – As you enter information the field will expand.				
<input type="text"/>				
UNDER THE BY-LAWS OF YOUR DEPARTMENT, ARE YOU A MEMBER IN GOOD STANDING?	YES:	<input type="checkbox"/>	NO:	<input type="checkbox"/>
MEMBER LENGTH OF YEARS/SERVICE TO THE DEPARTMENT?	YES:	<input type="checkbox"/>	NO:	<input type="checkbox"/>
HAVE YOU APPLIED FOR BENEFITS FROM THIS FUND IN THE PAST?	YES:	<input type="checkbox"/>	NO:	<input type="checkbox"/>
IF YES, PLEASE PROVIDE THE NATURE OF YOUR ILLNESS OR INJURY AND GIVE THE DATES: – As you enter information the field will expand.				
<input type="text"/>				

FORM A – NOTARY SECTION:

The form must be signed and notarized by a state certified notary. Please visit the following locations if you require a notary for your area:

- Maryland - [Search Notary Database \(site.com\)](#)
- District of Columbia [Notary Commissions | os \(dc.gov\)](#)
- Virginia [Secretary of the Commonwealth - Notary Commissions \(virginia.gov\)](#)
- West Virginia [WV SOS - Business and Licensing - Notaries - Online Data Services](#)
- Delaware [Delaware Notary Public - State of Delaware -](#)
- Pennsylvania [Home \(pa.gov\)](#)

IMPORTANT: No payment will be considered by the Bessie Marshall Benefit Fund committee until all three forms (A, B and C) are completely filled out and signed.

I hereby certify that the information contained herein is true and correct to the best of my knowledge.

Notary Printed Name

Member Printed Name

Notary Signature:

Member Signature

Notary Commission State Of:

Date

Notary Commission Expiration Date:

Notary Address of Commission:

Notary Seal

FORM B – DEPARTMENT CERTIFICATION FOR BENEFITS

TO COMPANY OFFICER: When a member of a company or department in good standing in the Maryland State Firemen’s Association is ill or injured (**NOT IN THE LINE OF DUTY**), one copy of this Certificate shall be signed by the President, Chief and Secretary and forwarded to the Chairmen of the Bessie Marshall Committee.

DATE: _____

COMPANY NAME: _____

COMPANY ADDRESS: _____

CITY _____ ZIP _____ COUNTY _____ STATE _____

PHONE NUMBER: _____

This is to certify that _____ is a
(Name of member)

Is a Fire _____ EMS _____ or Administrative Member _____ of our department and has been a member in good standing for (# _____) YEARS OF SERVICE.

Their duties are _____

By our signatures we certify that the information contained herein is true and correct to the best of our knowledge.

Secretary Print

President Print

Secretary Signature

President Signature

Secretary Phone Number

President Phone Number

Corporation/Department Seal

Chief Print

Chief Signature

Chief Phone Number

FORM C - MEDICAL RELEASE CERTIFICATION

PLEASE NOTE ONLY THE FOLLOWING MEDICAL PROVIDERS MAY SIGN/CERTIFY THE FORM. IF NOT SIGNED BY THE CORRECT PROVIDER THE FORMS WILL BE RETURNED.

MD – MEDICAL DOCTOR
CRNP – CERTIFIED REGISTERED NURSE PRACTITIONER

CNP – CERTIFIED NURSE PRACTITIONER
NP – NURSE PRACTITIONER

DATE: _____

I HEREBY CERTIFY THAT (PATIENT NAME) _____
HAS BEEN UNDER MY MEDICAL CARE FOR THE FOLLOWING CONDITION: *THIS INFORMATION WILL REMAIN PRIVATE. THIS ALLOWS THE COMMITTEE TO ENSURE THAT THE BENEFIT FOR THE MEMBER IS AWARDED PROPERLY AND MEETS THE CONDITIONS OF THE BESSIE MARSHAL BENEFIT FUND.*

DATE OF INJURY: _____

RETURN TO WORK: THE PATIENT MAY RETURN TO WORK ON OR ABOUT: _____
(DATE OR ESTIMATED DATE OF RETURN)

THE TREATMENT FOR THIS PATIENT IS MEDICALLY NECESSARY. YES NO

NAME OF MEDICAL PRACTICE: _____
ADDRESS OF MEDICAL PRACTICE: _____
OFFICE CONTACT NUMBER: _____
PRINTED NAME OF ATTENDING: _____
SIGNATURE OF ATTENDING: _____
<input type="checkbox"/> MEDICAL DOCTOR
<input type="checkbox"/> CRNP – CERTIFIED REGISTERED NURSE PRACTITIONER
<input type="checkbox"/> CNP – CERTIFIED NURSE PRACTITIONER
<input type="checkbox"/> NP – NURSE PRACTITIONER
MEDICAL LICENSE NUMBER OF ATTENDING: _____
DATE SIGNED: _____