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
Sharon Worthington, 314 Quaker Road, Havre de Grace, MD 21078
EMAIL: firelady95@comcast.net Contact Phone: 410-804-4076

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 Marshal 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

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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:

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

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

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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

_____
Secretary Signature

_____
Secretary Phone Number

Corporation/Department Seal

_____
President Print

_____
President Signature

_____
President Phone Number

_____
Chief Print

_____
Chief Signature

_____
Chief Phone Number

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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: _____

- ☐ **MEDICAL DOCTOR**
- ☐ **CRNP – CERTIFIED REGISTERED NURSE PRACTITIONER**
- ☐ **CNP – CERTIFIED NURSE PRACTITIONER**
- ☐ **NP – NURSE PRACTITIONER**

MEDICAL LICENSE NUMBER OF ATTENDING: _____

DATE SIGNED: _____