UC DAVIS HEALTH | REHABILITATION HOSPITAL

Financial Assistance Application

1. PATIENT INFORMATION			
Last Name	**First Name**	**Guarantor Account No.**	**Medical Record No.**

2. APPLICANT INFORMATION	RELATIONSHIP TO PATIENT	MARITAL STATUS
	☐ Self ☐ Spouse ☐ Parent ☐ Other	☐ Married ☐ Single ☐ Separated

Last Name	First Name

Date of Birth	No. of Dependents	Ages of Dependents	Phone Number ( )

Street Address (Do Not List PO Box)	City	State	County	Zip

3. Covid-19

Does the patient have a financial hardship due to the COVID-19 pandemic (job loss or reduction in hours)? ☐ **Yes** ☐ **No**

4. INCOME INFORMATION (Supporting documentation required)

Monthly Income Source	Applicant	Co-Applicant	Combined Monthly Income
Employment Income	$	$	$
Child Support	$	$	$
Alimony	$	$	$
Welfare	$	$	$
Gift	$	$	$
Other (Unemployment, Pension, etc.)	$	$	$
		Total Combined Monthly Income	$

Are you supplied room & board by family/friends? ☐ **Yes** ☐ **No**

5. Liquid Assets (Supporting documentation required)

Checking/Money Market/Savings Accounts:

Bank Name	Branch/Address	Current Balance
1.		$
2.		$
3.		$
Other Cash Assets (Securities/Stocks/Bonds/Cash Value of Insurance/Tax Refund/Etc.)		
1.		$
2.		$
	Total Asset Value	$

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6. Non-Liquid Assets

	Make/Year	Amount Owed	Monthly Payment	Value
1st Car		$	$	$
2nd Car		$	$	$
Other		$	$ ☐	$ ☐
Total (Exclude 1st Vehicle)		$	$ ☐	$ ☐
Do you own your primary residence?			Yes:	No:
Do you own property other than your primary residence?			Yes:	No:
Address/Locations:				

	Amount Owed	Monthly Payment	Value
Other Property	$	$	$
Add total of vehicle value plus other property equity = TOTAL NON-LIQUID ASSETS			$

7. Monthly Expenses

	Outstanding Balance	Monthly Payment
Child Support *(if a child is not claimed as a dependent)*	$	$
Mortgage / Rent	$	$
Groceries	$	$
General Bills (Utilities or reoccurring bills)	$	$
Other	$	$
Subtotal Expenses		$
Total Vehicle Payments from Section 6	$	$
Medical/Dental Expense *(Includes UCDH)*	$	$
Charge Accounts/Loans/Credit Cards:		
1.	$	$
2.	$	$
Total Expenses:		$

8. Signature and Date

PURPOSE: The purpose of this information is to determine your ability to pay for services at UCDH or your possible eligibility for a medical assistance program. This information is NOT an application for Medi-Cal, Sacramento County Medically Indigent Service Program or any other county's assistance program. YOU MUST CONTACT THE DEPARTMENT OF SOCIAL SERVICES IN YOUR COUNTY OF RESIDENCE TO APPLY FOR ASSISTANCE PROGRAMS.

I certify the above information to be accurate and complete. I understand that the hospital reserves the right to verify all information supplied. I agree to notify the UCDH Patient Billing Customer Service Department (916) 734 -9200 of any change in my financial information within 10 days of the change. I UNDERSTAND THAT I AM STILL RESPONSIBLE FOR THE FULL AMOUNT OF MY CHARGES AT UCDH.

_____ _____

Signature of Patient / Responsible Party | Date

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