UC DAVIS HEALTH | REHABILITATION HOSPITAL

# Financial Assistance Application

| **Patient Information** | | | |
|---|---|---|---|
| Last Name | First Name | Guarantor Acct. Number | MRN |
| **Applicant Information** | | | |
| Last Name | First Name | DOB | Phone Number |
| Street | City | County | Zip Code |
| Number of Dependents | Ages of Dependents | Relationship to Patient | Marital Status |
| **Monthly Income Information** (supporting documentation required) | | | |
| Source | Applicant | Co-Applicant | Combined |
| Employment Income | $ | $ | $ |
| Child Support | $ | $ | $ |
| Alimony | $ | $ | $ |
| Welfare | $ | $ | $ |
| Gift | $ | $ | $ |
| Unemployment | $ | $ | $ |
| Pension | $ | $ | $ |
| Other | $ | $ | $ |
| | | Total Combined Monthly Income | $ |
| **Monthly Expenses** | | | |
| Expense | | Outstanding Balance | Monthly Payment |
| Mortgage/Rent | | $ | $ |
| Child Support | | $ | $ |
| Groceries | | $ | $ |
| Utilities | | $ | $ |
| Vehicle Payments | | $ | $ |
| Medical/Dental | | $ | $ |
| Charge Accounts/Credit Cards/Loans | | $ | $ |
| Other | | $ | $ |
| | Total | | |

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| Certification | |
|---|---|
| **PURPOSE:** The purpose of this information is to determine your ability to pay for services at UCDRH 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 UCDRH Controller (279) 224-6002 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 UCDRH. | |
| **Signature of Patient / Responsible Party** | **Date** |