UC DAVIS HEALTH | REHABILITATION HOSPITAL

Financial Assistance Application

Patient Information

Last Name: _____ First Name: _____
MRN: _____ Guarantor Acct. Number: _____

Applicant Information

Last Name: _____ First Name: _____
DOB: _____ Phone Number: _____
Address: _____
County: _____
Number of Dependents: _____ Age 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 $_____

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Monthly Expenses (only needed for payment plan estimates)

Expense	Outstanding Balance	Monthly Payment
Mortgage/Rent	$	$
Child Support	$	$
Groceries	$	$
Utilities	$	$
Vehicle Payments	$	$
Medical/Dental	$	$
Charge Accounts/Credit Cards/Loans	$	$
Other	$	$
Total	$	$

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**