UC Davis Rehabilitation Hospital Financial Assistance Application

Patient Information

Patient Name _____

Address _____

Phone Number _____

Date of Birth _____

Social Security Number _____

Insurance Coverage

Do you have health insurance _____

Guarantor _____

Guarantor Account Number _____

Do you have other insurance that may apply (such as an auto policy) _____

Were your injuries caused by a third party (such as car accident or slip and fall) _____

Family Status

Adult Patients: For patients eighteen (18) years of age and older (except for dependent children aged 18-20, addressed below) the patient family includes their spouse, domestic partner, dependent children under twenty-one (21) years of age, and a dependent child of any age if the dependent child is Disabled. Children meeting the criteria in this subsection are considered part of the family whether living at home or not.

Dependent Child Aged 18-20: For patients who are dependent children aged eighteen (18) to twenty (20), inclusive, the patient family includes their parent(s), caretaker relative(s), other dependent children under twenty-one (21) years of age of the parent(s) or caretaker relative(s), and a child of the parent(s) or caretaker relative(s) of any age if the child is disabled.

Name, Age, Relationship _____

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Name, Age, Relationship _____

Name, Age, Relationship _____

Employment and Occupation

Employer _____

Position _____

Contact Person and Telephone _____

Name of Business if Self-Employed _____

Current Monthly Income

Include: patient and family

Gross Pay (before deductions) _____

Income from Operating Business (self-employed) _____

Income from Interest and Dividends _____

Income from Real Estate or Personal Property _____

Social Security Income _____

Other Income (specify) _____

Alimony or Support Payments Received _____

Alimony or Support Payments Paid (subtract) _____

Total Monthly Income (patient and family) _____

Certification

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.

Signature_____

Date_____