UC DAVIS HEALTH

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 on Current Tax Return**	**Ages of Dependents**	**Phone Number** ( )

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

3. 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**

4. 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.

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Signature of Patient / Responsible Party Date