Household Information and Financial Assessment

Member Name	Age	Relationship	Employer	Annual Gross Income

Total Family Size: _____ Total Dependents: _____ Total Household Gross Income: _____

Monthly Expenses

Rent/Mortgage $_____

Utilities $_____

Food $_____

Household Supplies $_____

Auto Expenses $_____

Medical $_____

Child Care $_____

Clothing $_____

Auto Ins $_____

Other $_____

Income and Assets

Checking Accounts(s) $_____

Savings Account(s) $_____

Other Cash Assets $_____

Employment Income $_____

Spouse Income $_____

SSI $_____

Disability Income $_____

Child Support $_____

Other $_____

Total Monthly Gross Income $_____

Total Monthly Expenses $_____

Total Monthly Gross Income minus Total Monthly Expenses = $_____

To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.

_____ _____

PATIENT/GUARANTOR SIGNATURE Date

Oroville Hospital

Confidential Community Care Application

Patient Information

Date(s) of Service: _____ Account Number(s):_____

Patient Name: _____ Date of Birth: _____ SS#_____

Marital Status: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____

Address: _____City: _____ State: _____Zip: _____

Employers Name and Address: _____

Spouse Name: _____ Spouse Date of Birth: _____

Screening Information

Do you currently have health insurance? (Y/N) If yes, name of insurance: _____

- Eligible for California Health Exchange or other State or county funded health coverage as well Medicare, Medi-Cal, Health Families, and California Children's Services (Y/N)
- If yes: _____

Have you applied for health insurance in the past 3 months? (Y/N)

- If yes, what type? _____

Have you had health insurance in the past 3 months? (Y/N)

- If yes, reason for insurance termination? _____
- Eligible for Cobra? (Y/N) If yes, premium amount is: _____ Payment Due Date: _____
- Eligible for Covered CA Enrollment? (Y/N)
- Would you like assistance with your Covered CA application (Y/N)

Are you active military? (Y/N)

- If yes, are you eligible for VA medical benefits? (Y/N)

Were you a victim of a crime? (Y/N)

- If yes, have you filed a Police Report? (Y/N) Must be filed within 72hrs of incident)
  - Completed Victim of Crime application (Y/N)

Oroville Hospital

OROVILLE HOSPITAL
COMMUNITY CARE / FINANCIAL ASSISTANCE

Completed Community Care / Financial Assistance Application

A complete copy of your most current Income Tax Return.

Three (3) Current Pay Stubs for all income in the home, for all family members receiving income, including Retirement, Pensions, Unemployment, Disability, Public Assistance etc.

Proof of Application for Medi-Cal / CMSP / Path2Health, **OR** Notice of Action stating Denial or Approval of Benefits

Prior two (2) Months of Bank Statements for all Checking and Savings Accounts for Personal and Business Accounts

Verification of IRA's, CD's, Annuities, Life Insurance, Trust Accounts

Itemized list of your monthly payments, ie Utilities, Car Payments, Mortgage/Rent etc.

Other:

Respectfully,

Patient Financial Services
530-538-8766