UC DAVIS HEALTH | REHABILITATION HOSPITAL

Financial Assistance Application

1. PATIENT INFORMATION

Last Name	First Name	Guarantor Account No.	Medical Record No.

2. APPLICANT INFORMATION

Last Name	First Name	RELATIONSHIP TO PATIENT	MARITAL STATUS
		☐ Self ☐ Spouse ☐ Parent ☐ Other	☐ Married ☐ Single ☐ Separated

Date of Birth	No. of Dependents	Ages of Dependents	Phone Number
			( )

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

3. Covid-19

Does the patient have a financial hardship due to the COVID-19 pandemic (job loss or reduction in hours)? Yes ☐ No ☐

4. 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	$

☐ ☐

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5. Monthly Expenses

	Outstanding Balance	Monthly Payment
Child Support ***(if a child is not claimed as a dependent)***	$	$
Mortgage / Rent	$	$
Groceries	$	$
General Bills (Utilities or reoccurring bills)	$	$
Other	$	$
	Subtotal Expenses	$
Total Vehicle Payments from Section 6	$	$
Medical/Dental Expense ***(Includes UCDH)***	$	$
Charge Accounts/Loans/Credit Cards:		
1.	$	$
2.	$	$
	Total Expenses:	$

6. 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 (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 UCDH.

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Signature of Patient / Responsible Party   Date