UCDAVIS HEALTH

Financial Assistance Application

1. PATIENT INFORMATION			
Last Name	First Name	Guarantor Account No.	Medical Record No.

2. APPLICANT INFORMATION	RELATIONSHIP TO PATIENT Self Spouse Parent Other	MARITAL STATUS Married Single Separated
Last Name	First Name	

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	$
Are you supplied room & board by family/friends?		**Yes**	**No**

5. Liquid Assets (Supporting documentation required)		
Checking/Money Market/Savings Accounts:		
Bank Name	**Branch/Address**	**Current Balance**
1.		$
2.		$
3.		$
Other Cash Assets (Securities/Stocks/Bonds/Cash Value of Insurance/Tax Refund/Etc.)		
1.		$
2.		$
	Total Asset Value	$

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6. Non-Liquid Assets

	Make/Year	Amount Owed	Monthly Payment	Value
1st Car		$	$	$
2nd Car		$	$	$
Other		$	$	$
Total (Exclude 1st Vehicle)		$	$	$
Do you own your primary residence?			Yes:	No:
Do you own property other than your primary residence?			Yes:	No:
Address/Locations:				
		Amount Owed	Monthly Payment	Value
Other Property		$	$	$
Add total of vehicle value plus other property equity = TOTAL NON-LIQUID ASSETS				$

7. 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:		$

8. 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.

____________________________________ Signature of Patient / Responsible Party

____________________ Date