USE PATIENT PLATE

UNIVERSITY OF CALIFORNIA, DAVIS
MEDICAL CENTER

PATIENT FINANCIAL INFORMATION

Patient's Name: ______________________

Account Number: ______________________

SECTION I FAMILY/GUARANTOR INFORMATION

Total Number in Family: ____________

# of Dependents Under 21: ____________

Name of Guarantor & Relationship to Patient:

____

Citizenship Status of Patient:: ______________________

Section #: ________ Dates of Status: ________ Amnesty #: ________

	Yes	No
Nursing Home Residents:	Yes ______	No ______
Disabled:	Yes ______	No ______
Pregnant:	Yes ______	No ______
Legally Blind:	Yes ______	No ______
Social Security Disability SSI/SSP Application Pending:	Yes ______	No ______
Victim of Crime:	Yes ______	No ______

SECTION II GROSS MONTHLY INCOME

	AMOUNT
EARNED INCOME (SALARY, WAGES, TIPS, ETC.)	
Circle one or more	
Patient/Father	$ ________
Spouse/Mother/Other (Specify)	$ ________
UNEARNED INCOME	
Check all appropriate	
☐ Disability Income	$ ________
☐ Retirement	$ ________
☐ General Assistance	$ ________
☐ Other (circle all appropriate)	$ ________

Unemployment Insurance	Veterans Benefits
Social Security	Workers' Compensation
Child Support	Alimony
Contributions	Interest
Dividends	Income from Property
Loans	

TOTAL INCOME .... $ ________

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

SECTION III LIQUID ASSETS

Checking Account Number: ______________________

Bank/Credit Union Name: ______________________ . . $ ________

Branch: ______________________

Savings Account Number: ______________________

Bank/Credit Union Name: ______________________ . . $ ________

Branch: ______________________

Securities/Stocks/Bonds/Cash Value of Insurance/Tax Refund/etc.

(Specify) ______________________ . . $ ________

TOTAL LIQUID ASSETS: .... $ ________

SECTION IV NON-LIQUID ASSETS

All Vehicles Owned (Circle All Appropriate)

	Make	Year	Amt Owed	Mo Pmt	Value
1st Car	______	______	$ ______	$ ______	$ ______
2nd Car	______	______	$ ______	$ ______	$ ______
Truck/Motorcycle	______	______	$ ______	$ ______	$ ______
Boat/Camper/RV	______	______	$ ______	$ ______	$ ______
Other	______	______	$ ______	$ ______	$ ______
Total (exclude 1st vehicle)			$ ______	$ ______	$ ______

Do you own or rent residence? Own ______ Rent ______

Do you own property other than residence? Yes ______ No ______

Address/Location:

	Value	Amt Owed	Equity
Other Property	$ ______	$ ______	$ ______

Add total of vehicle value
plus other property equity = TOTAL NON-LIQUID ASSETS $ ________

SECTION V MONTHLY EXPENSES

	TOTAL AMOUNT DUE	MONTHLY PMT or EXPENSE
Alimony and/or Child Support (if a child is not claimed as a dependent)	$ ______	$ ______
Day Care Costs for Children (for working parents)	$ ______	$ ______
Cost of Health Insurance Premiums	$ ______	$ ______
Work Expense ($75 per working person)	$ ______	$ ______
Subtotal Expenses	$ ______	$ ______
Total Vehicle Payments from Section IV	$ ______	$ ______
Total Medical/Dental Expenses (including UCDMC)	$ ______	$ ______
Charge Accounts/Loans/Credit Cards:		
Name: ______________	$ ______	$ ______
Name: ______________	$ ______	$ ______
Name: ______________	$ ______	$ ______
Mastercard Limit $ ________	$ ______	$ ______
Visa Limit $ ________	$ ______	$ ______
Subtotal	$ ______	$ ______
TOTAL EXPENSES	$ ______	$ ______

Remarks:

PURPOSE: The purpose of this information is to determine your ability to pay for services at UCDMC or your possible eligibility for a medical assistance program. This information is NOT an application for Medi-Cal, Sacramento County Medically Indigent Services 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 UCDHS 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 UCDMC.

______________________ ______________
Signature of Patient / Responsible Party **Date**

______________________ ______________
Witness / Translator (Translator Disclaimer) **Hospital Representative**