UNIVERSITY of CALIFORNIA, SAN DIEGO
MEDICAL CENTER

FINANCIAL SCREENING

NAME
MEDICAL RECORD #
AGE/SEX
DOB

FAMILY SIZE	Source	Date
NUMBER OF CHILDREN IN HOME (UNDER 21)		

Patient Identification

RESIDENCY

How long have you lived at current address? _____ Do you plan to move? ❒ No ❒ Yes, where? _____

NAME / SOCIAL SECURITY NUMBER	AGE	HOURLY WAGE / AVG HRS/WK	# HOURS ANTICIPATED THIS MONTH	ANTICIPATED MONTHLY GROSS	EMPLOYER NAME / EMPLOYER PHONE	PAID VACATION/ SICK LEAVE	EMP. TYPE CODE	HEALTH INSURANCE
1 PATIENT (If under 21, living with parents, must list parents' income(s))		$		$				
2	REL	$		$				
3		$		$				
4		$		$				

SOURCE CODE - INCOME OTHER THAN WAGES
C - Child Support
GR - General Relief
O - Other_____
R - Retirement_____
SDI - State Disability Insurance
SS - Social Security Disability
U - Unemployment Income
WMC - Workers' Compensation

INCOME OTHER THAN WAGES #	SOURCE CODE	
		$
		$
		$

MEDICAL HISTORY
1. Is this medical condition related to an on the job injury? ❒ No ❒ Yes
2. Is this medical condition the result of an accident? ❒ No ❒ Yes
   If yes, where did the accident occur? _____
   when did the accident occur? _____
3. Did you receive treatment for this injury/illness before coming to UCSD? ❒ No ❒ Yes
   If yes, where _____
   when _____

Comments: _____

EMPLOYMENT TYPE CODE
P/T - Professional/ Technician
L - Labor/Production
A - Agriculture
S - Service/Sales
O - Other_____

DEDUCTIONS FROM INCOME
Court ordered child support/alimony _____
Amount paid for child care _____
Paid health insurance premiums _____
Subtotal _____

SUBTOTAL (OTHER) $
SUBTOTAL (WAGES)
TOTAL $

FINANCIAL INFORMATION

	YES	NO					
Do you own the home you live in?			MONTHLY MORTGAGE	VALUE	BALANCE OWED	BANK	
Do you own other property in the US?			LOCATION	MONTHLY MORTGAGE	VALUE	BALANCE OWED	BANK
Do you own other property outside US?			LOCATION	MONTHLY MORTGAGE	VALUE	BALANCE OWED	BANK
Do you own any other assets (trust deeds, trust fund)?			VALUE				
Do you pay rent where you live?			AMOUNT	LANDLORD NAME		PHONE #	
Did you pay this month's rent?							
Do you receive free room and board?			NAME OF PROVIDER			PHONE #	
Are you homeless?			NAME OF SHELTER			PHONE #	
If yes, are you connected with a shelter?							
Do you have friends/relatives in the area?			NAME OF FRIEND/RELATIVE				

Cash on hand	$		
Savings	$	NAME OF BANK/INSTITUTION	BRANCH
Checking	$	NAME OF BANK/INSTITUTION	BRANCH

Credit card	TYPE	ACCOUNT NUMBER	BALANCE	LIMIT
	TYPE	ACCOUNT NUMBER	BALANCE	LIMIT
	TYPE	ACCOUNT NUMBER	BALANCE	LIMIT

Life insurance cash surrender value	$	NAME
Face value of insurance policy	$	

NAME OF MEDICAL CENTER REPRESENTATIVE

Automobile/RV/ Trailer/Motorcycle	YEAR	INSURANCE CO.
1		
2		PHONE
3		

	YES	NO	MARKET VALUE
IRA			
Keough			
401K			
Stocks/bonds			
Other:			

I certify the information hereon to be accurate and complete. I understand that the Medical Center reserves the right to verify all information supplied.

Signature of Patient/Guarantor Date

EMANCIPATED MINOR CERTIFICATION

I, the above-referenced patient, state that I am a minor living separate and apart from my parents and managing my own financial affairs.

Patient Signature Date

WHITE - Packet YELLOW - HOS/CPS PINK -CPSD GOLD - Patient

UNIVERSITY OF CALIFORNIA PRIVACY NOTICE
FINANCIAL AND MEDICAL RECORDS

I. The State of California Information Practices Act (IPA) of 1977 requires the University of California hospitals to give you the following information about why we need to obtain and record personal information about you.

II. Authority to Obtain/Maintain Information: We need information about you to assure accurate identification and consistency of medical care, as well as for our financial records and billing activities. We are authorized to obtain and maintain this information by federal statutes, the California Administrative Code (Title 22-Licensing and Certification of Health Facilities and Referral Agencies), and University of California policy.

III. Voluntary Information: We need, if you can provide it, as much of your and your family's past medical history as possible. We need identifying information so that, if necessary, we can get your other pertinent medical records and so we can bill your medical insurance carrier. This kind of information can help us provide better care than if we had to treat you without it, and it lets us assist you in handling the financial part of your health care.

IV. Medical Review Organization (for federally funded patients, Medicare, Medi-Cal, Maternal and Child Health): There is a Medical Review Organization to which we must provide information about your hospitalization as a check on whether your admission, length of stay, transfer, and the tests and procedures we perform are appropriate for your diagnosis. We do not collect any extra information about you for this purpose. If at any time during your stay it is found that the type of care you need should be provided in a different type of health care facility, you and your physician will be notified in writing, and your federal funding must be terminated for your current hospitalization in our facility.

V. Safeguards to Privacy: We consider your records confidential, and , except as indicated below, your privacy is protected because we usually need your authorization to release information about you. We may release some information without your consent in certain cases, such as to your referring physician (unless you instruct us otherwise), to University faculty and students for research and educational purposes (in accordance with our respect for your privacy, nothing that identifies you is revealed by them), non-medical information to appropriate parties to permit effective management and collection of hospital and physician bills, or if required by law (for example, contagious disease reports to public health agencies).

VI. Right to Review Records: You have the right to review your records (in most cases) in accordance with the IPA and University Policy. Information about these policies can be obtained from the officials responsible for keeping the information:

Medical Record	**Billing File**	**UCSD Medical Group**	**Medical Review Organization**
Director Health Information Services UCSD Medical Center 200 West Arbor Drive 91764 San Diego, CA 92103 (619) 543-6700	Office of the Manager Patient Billing and Collections UCSD Medical Center 200 West Arbor Drive San Diego, CA 92103 (619) 543-3000	PO Box 232410 San Diego, CA 92103 (619) 543-1854	3435 Wilshire Blvd. Suite 200 Los Angeles, CA (213) 738-5400

VII. Privacy Notice - Social Security Number: Under the authority of The Regents of the University of California (Article IX, Section 9 of the California Constitution), the hospital has maintained record systems which require your social security number to verify your identity. These record systems have been in effect since before 1 January 1975.

In accordance with the Federal Privacy Act of 1974, you are notified that we may request your social security number (especially for Medicare, which requires it) to verify your identity in our medical care and payment systems. Such a request would be in keeping with Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act, as amended.