PATIENT FINANCIAL DISCLOSURE STATEMENT

Date of Disclosure:_________ Patient Name:_____________________________

Guarantor Name:____

Address: ____

Sex: _____ Guarantor Date of Birth: ______________________________________

Length of Residence:____________________ Rent: __________ Own: ____________

Phone (_____)_________________________ Social Security # ___________________

Check One: Married: ________ Single: ______ Divorced: ______ Separated:_____

Household Members (All persons living in the home plus dependents not living in the home)

Name:	Age:	Where Employed:

Family Services:
Are you eligible for Medi-Cal? Y ____ N_____ Don't know ______
Have you ever applied for Medi-Cal? Y ____ N_____ Don't know ______
Do you receive Food Stamps? Y ____ N_____ Don't know ______
If yes, amount $__________

Social Security:
Do you receive Social Security income: Y ____ N_____
Do you receive Social Security Disability? Y ____ N_____
Do you receive Supplemental Security Income? Y ____ N_____
(SSI Gold Check)

Veterans:
Are you a veteran? Y ____ N_____
If yes, do you have a service connected disability? Y ____ N_____
Do you have a claim number? Y ____ N_____
If yes, please provide the number:_______________

Family Income:
Please note that patients who are applying for the Discount Plan need only include proof of income, if any. Assets are **not** required to be listed. Patients who are applying for Charity Care need to include proof of income **and** assets, if any.

Please list all sources of income received in the past 3 months. (Sources of income may include: employment, food stamps, social security income / green check, supplemental security income / SSI gold check, veteran's benefits, unemployment compensation, child support, alimony, pensions, etc.)

Name of Person Receiving Income:	Source of Income:	Social Security #	Amt. of Monthly Income After Taxes:
____________	______	__________	$__________
____________	______	__________	$__________
____________	______	__________	$__________
		Total Income Per Month:	$__________

Expenses:

Type:	Monthly Payment:	Balance Due:
____________	$______________	$__________
____________	$______________	$__________
____________	$______________	$__________
____________	$______________	$__________
____________	$______________	$__________
____________	$______________	$__________
Total	$______________	
Disposable Income: (Income / Expenses)	$______________	

Assets:

Cash on Hand:	$__________		
Checking Account No.	__________	Balance:	$__________
Savings Account No.	__________	Balance:	$__________
Automobile (year of car)	__________	Value:	$__________
Home Value	$__________	Loan: (Balance)	$__________

All persons are prohibited from giving to any hospital in this state a false or fictitious name, a false or fictitious address, or any other false or fictitious information that is required to be obtained by such hospital in compliance with state and federal laws. All persons are also prohibited from assigning to any hospital the proceeds of any insurance contract, then knowing that such contract is no longer in force or is invalid or is void for any reason. Such action shall be evidence of the intent of such persons to defraud such hospital.

I certify that the above stated information is true and correct. I authorize College Hospital to contact the employers institutions on this application or a credit reporting agency to verify its accuracy. I further authorize the employers, institutions and/or credit reporting agencies to release such information to College Hospital.

______________________________ ______________________________

Signature Date

______________________________ ______________________________

Reviewed By Date