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 #: ________

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