Confidential Community Care Application

Patient Information

Date(s) of Service: _____ Account Number(s):_____

Patient Name: _____ Date of Birth: _____ SS#_____

Marital Status: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____

Address: _____City: _____ State: _____Zip: _____

Employers Name and Address: _____

Spouse Name: _____ Spouse Date of Birth: _____

Screening Information

Do you currently have health insurance? (Y/N) If yes, name of insurance: _____

- Eligible for California Health Exchange or other State or county funded health coverage as well Medicare, Medi-Cal, Health Families, and California Children's Services (Y/N)
- If yes: _____

Have you applied for health insurance in the past 3 months? (Y/N)

- If yes, what type? _____

Have you had health insurance in the past 3 months? (Y/N)

- If yes, reason for insurance termination? _____
- Eligible for Cobra? (Y/N) If yes, premium amount is: _____ Payment Due Date: _____
- Eligible for Covered CA Enrollment? (Y/N)
- Would you like assistance with your Covered CA application (Y/N)

Are you active military? (Y/N)

- If yes, are you eligible for VA medical benefits? (Y/N)

Were you a victim of a crime? (Y/N)

- If yes, have you filed a Police Report? (Y/N) Must be filed within 72hrs of incident)
    - Completed Victim of Crime application (Y/N)

Household Information and Financial Assessment

Member Name	Age	Relationship	Employer	Annual Gross Income

Total Family Size: _____ Total Dependents: _____ Total Household Gross Income: _____

Monthly Expenses

Rent/Mortgage $_____

Utilities $_____

Food $_____

Household Supplies$ _____

Auto Expenses $_____

Medical $_____

Child Care $_____

Clothing $_____

Auto Ins $_____

Other $_____

Income and Assets

Checking Accounts(s) $_____

Savings Account(s) $_____

Other Cash Assets $_____

Employment Income $_____

Spouse Income $_____

SSI $_____

Disability Income $_____

Child Support $ _____

Other $_____

Total Monthly Gross Income $_____

Total Monthly Expenses $_____

Total Monthly Gross Income minus Total Monthly Expenses = $_____

To my knowledge the information provided above is true. I authorize a Credit Bureau Report to be secured by the Hospital or its agent to verify my financial standing.

_____ _____

PATIENT/GUARANTOR SIGNATURE Date