



## Application for Financial Assistance

### Applicant information:

Patient Name:		Spouse Name:	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Life Partner			
Address:			
Home Phone:		Cell Phone:	Spouse Cell Phone:
Date of Birth: <i>(Patient)</i>		Date of Birth: <i>(Spouse)</i>	
Employer: <input type="checkbox"/> Full time <input type="checkbox"/> Self <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Seasonal		Employer: <input type="checkbox"/> Full time <input type="checkbox"/> Self <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Seasonal	
Occupation:		Occupation:	

List your dependents currently living with you:

Name	Date of Birth	Age	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

INCOME: LIST MONTHLY INCOME FOR FAMILY		EXPENSES: LIST MONTHLY EXPENSES FOR	
Wages Self		Mortgage/Rent <i>(including maintenance)</i>	
Spouse		Utilities <i>(electricity, water, garbage, sewer)</i>	
Other Family Members		Telephone	
Farm or Self Employments		Food and household supplies	
Public Assistance		Finance Companies	
Social Security		Credit Cards	
Unemployment Compensation		Credit Union	
Strike Benefits		Auto Loans	
Alimony		Transportation/Auto <i>(Insurance, fuel, repairs)</i>	
Child Support		Insurance <i>(medical, dental, life, home)</i>	
Military Family Allotment		Medical Bills – Hospital, Doctor, Medication	
Pensions		Clothing and Laundry	
Income from Dividends, Interest, Rent		School and Child Care	
Other Income		Child and Spousal Support	
		Installment Payments	
<b>Gross Family Income</b>		<b>Total Expenses</b>	
		<b>BALANCE (Income – Expenses)</b>	

**Assets and Liabilities: (please provide current statements)**

<b>Assets</b>	<b>Market Value</b>	<b>Company/Acct#/Location</b>
Cash in Checking Account		
Cash in Savings Account		
Certificates of Deposit		
<b>A. Total Cash</b>		

Investments – Stock		
– Bonds		
– Mutual Funds		
– Other ( )		
<b>B. Total</b>		

Principal Residence ( <b>not counted in total</b> )		
Other Real Estate		

Vehicles – Year/Make/Model		
Primary: ( <b>not counted in total</b> )		
Second:		
Third:		
<b>C. Total</b>		

Personal Property List (i.e. Boats)		
1.		
2.		
3. Other Misc. (i.e. Jewelry/Collectibles)		
<b>D. Total</b>		

<b>E. Total Assets (A + B + C + D = E)</b>		
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<b>Debts/Loans Outstanding</b>		
Mortgage – Principal Residence ( <b>not counted in total</b> )		
Other Debt on Property (real estate)		
Debt on Auto (excluding primary auto)		
Debt on Personal Property		
Credit Cards (Company/Account #)		
1.		
2.		
3.		
<b>F. Total</b>		

Other Debts/Loans (Describe)	
1.	
2.	
<b>G. Total</b>	
<b>H. Total Debts/Loans Outstanding</b>	

<b>Net Worth (E - H)</b>	
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Possible Links to Categorical Funding:

**NOTE:** The requested information below will be used solely to determine linkage to available funding programs and will not impact your clinical care.

- Are you or will you be disabled for more than 1 year? Y    N
- Are you a veteran of the armed forces? Y    N
- If female, have you been diagnosed with breast or cervical cancer? Y    N
- Are you seeking assistance for reproductive health needs (*pregnancy or contraceptive request*)? Y    N
- Do you or your family members have any other conditions for which you are seeking treatment or need assistance? Y    N

**Required Documentation - Identity, Residency, Finances**

1. **US Government/State issued photo I.D.**
2. **Social Security Card** (*if applicable*)
3. **Proof of citizenship or permanent residency** (*for MAP only*)
4. **Proof of residency** (*utility bill, even if under a different name*).
5. Mortgage statement, rent receipts or rental contract.
6. Pay stubs - last four from all sources (*employment, unemployment, work comp, disability, etc.*)
7. Bank statements – last 2 months (all pages)
8. Complete income tax return; personal and business taxes. (*Most recent, including all W-2's and schedules*) If you do not have a copy, call 1-800-829-1040 for a tax transcript.
9. Proof of employer offered/not offered benefits on company letterhead. (*for MAP only*)
10. Covered California/Medi-cal/SSI/SSDI Case Documentation; Pending and Denial (*if applicable*).
11. Asset documentation (example: vehicle registration, IRA, 401K, stocks, bonds, mutual funds, whole life insurance policy with proof of current cash-out value, and any employer issued retirement accounts). (*if applicable*)

**By signing this document, I give San Joaquin County authorization to verify any information contained on this form. I give San Joaquin County authorization to obtain any other information to determine my financial liability. I declare under perjury the information contained on this form is true and correct.**

Date:	(Signature of Applicant or Guarantor)
Date:	(Signature of Spouse)