SANTA CLARA VALLEY MEDICAL CENTER
751 SOUTH BASCOM AVENUE
SAN JOSE, CA 95128

MED REC # _____
ACCOUNT # _____
Social Security # _____
Name: _____
Phone # _____

FINANCIAL ASSISTANCE APPLICATION

Are you a resident of Santa Clara County? _____ For how long? _____

Address? _____

Are you married? _____ Are you pregnant? _____ Previous hospital admits? _____

Does your spouse live with you? _____

Spouse name? _____ Spouse Soc Sec #? _____

If not, where does s/he live? _____

Do you have any children under 21? _____ How many? _____
List names, dates of birth and Soc. Sec. numbers on final page

Do other adults in your household support you? _____ Their income? _____
List names, dates of birth and Soc. Sec. numbers (if known) and relationship on final page

Do your minor children live with you? _____ If not, where do they live? _____

Who do they live with? _____

Do you have any adult dependents? _____
List names, dates of birth and Soc. Sec. numbers on final page

Are you currently covered by Medi-Cal or Medicare? _____ Have you ever had Medi-Cal? _____

Are you a US Citizen? _____ If not where were you born? _____

Have you provide proof of U.S. citizenship? _____

Do you have a Resident Alien card? _____ Do you have a Visa? _____

Is it active? _____
You must provide a copy of your Visa or Resident Alien card

Are you returning to your country of origin? _____ When? _____

Are you currently employed? _____ If yes, how long? _____

Who is your employer? _____

How many employees does this employer have? _____ Phone #? _____

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FINANCIAL ASSISTANCE APPLICATION CONTINUED

If you are not employed, how long ago was your last job? _____

Who was your last employer? _____

What is your insurance information? _____

If not employed, are you permanently disabled? _____ Blind? _____ On unemployment? _____

On state disability for a temporary problem? _____ On Worker's comp? _____

Do you receive GA? _____

Income from other sources? _____ Provide Details _____

If not, who supports you? _____ Are you claimed on anyone's taxes? _____

Do you own your own home? _____ Address? _____

Do you have any bank accounts? _____ Bank? _____

Checking amount? _____ Savings amount? _____

Have any stocks or other assets? _____ What are they? _____
Where? _____ Amount? _____

Was this visit the result of an accident? _____ A violent crime? _____

Provide details. _____

Gross Income:

Patient: _____

Gross Income:

Spouse: _____

Gross Income=income before deductions. Is income hourly, weekly or monthly? If hourly, include hours worked.

I/We certify under penalty of perjury by my/our signature that the information I/we have provided as required in the foregoing document is true and complete to best of my/our knowledge and belief. I/We also certify by my/our signature that we understand all the foregoing and that I/we agree to sign this agreement without any reservation whatsoever.

_____ _____

Patient Signature/Date

Interviewer Signature/Date

form date 5/10/07

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MED REC #
ACCOUNT #
NAME:

FINANCIAL ASSISTANCE APPLICATION: FINAL PAGE

List names, dates of birth and Soc. Sec. numbers and relationship of dependents and non-dependents living in the household