Patient Name:_____
Social Security #:_____Birthdate:_____
Address:_____
City:_____State:_____Zip:_____
Phone:_____Account Number:_____
Can you pay a portion: (Yes) (No) circle one if so how much?:_____
Did you apply for Medi-Cal: (Yes) (No) circle one. When:_____
if denied, why?_____

Section I

Family/Guarantor Information

Total Number in family:_____

Number of Dependents under 21:_____

Nursing Home Resident: (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

Earned Income(Salary/Wages/Tips,Etc.

Check one or more

□ *Patient* □ *Father* □ *Other* $_____ $_____

□ *Spouse* □ *Mother* □ *Other* $_____ $_____

Employer:_____Phone:_____

Other Income *Check all appropriate*

□ *Disability Income* $_____

□ *Retirement* $_____

□ *General Assistance* $_____

Other Income *Check all appropriate*

□ *Unemployment Insurance* □ *Veterans Benefits*

□ *Social Security* □ *Workers Comp*

□ *Child Support* □ *Alimony*

□ *Contributions* □ *Interest*

□ *Dividends* □ *Property Income*

Section III

Non-Liquid Assets

All Vehicles Owned (check all appropriate)

Make *Year* *Amount Owed*

□ *1st car* _____ _____

*Value $*_____ $_____

□ 2nd car _____ _____ $_____

*Value $*_____

□ *Truck/Mortocycle*

_____ _____ $_____

*Value $*_____

□ *Boat/Camper/RV*

_____ _____ $_____

Value $ _____

□ *Other* _____ _____ $_____

Value $ _____

*Subtotal Value $*_____

Do you own your home (Yes) (No)

*Value $*_____ *Payment:$*____

Do you own property other than residence?

(Yes) (No)

*Address/Location*_____

_____

Add total of vehicle value plus other property

Total Non-Liquid Assetts: $_____

□ *Loans*

Total Income: *$*_____

Are you supplied room & board by family/friends

□ *Yes* □ *No*

Section IV

Liquid Assets

*Checking Account No: $*_____

*Bank/Credit Union Name:*_____

*Branch:*_____

*Savings Account No: $*_____

*Bank/Credit Union Name:*_____

*Branch:*_____

Securities/Stocks/Bonds/Cash Value of Insurance/

Tax Refund/Etc.

*Specify:*_____

_____

*Total Liquid Assets:$*_____

Section V

Monthly Expenses	*Monthly pymt*
□ *Mortgage/Rent*	*$*_____
□ *Utilities*	*$*_____
□ *Telephone*	*$*_____
□ *Food*	*$*_____
□ *Finance Companies/Banks*	
□ *Credit Union*	*$*_____
□ *Insurance*	*$*_____
Health	*$*_____
Auto	*$*_____
Home	*$*_____
□ *Auto loans*	*$*_____
□ *Medical Bills*	
Hospital	*$*_____
Physicians	*$*_____
Medications	*$*_____
□ *Child Support/Alimony*	*$*_____
□ *Alimony*	*$*_____
□ *Day Care Cost*	*$*_____
□ *Charge Accounts/Credit Cards*	
*Name:*_____	*$*_____
*Name:*_____	*$*_____
*Name:*_____	*$*_____
□ *Gas for Car*	*$*_____
□ *Other*	*$*_____
Total Expenses:	*$*_____

PURPOSE: The purpose of this information is to determine your ability to pay for services at Glenn Medical Center or your possible eligiblity for a medical assistance program. This information is **NOT** an application for Medi-Cal, 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 Glenn Medical Center reserves the right to verify all information supplied I agree to notify Glenn Medical Center patient accounts department of any change in my financial information within 10 days of the change.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY:

_____ DATE:_____