San Mateo Medical Center's Patient Financial Status Form (Appeal Level 1)

Name of Applicant _____
Applicant Birthdate _____/_____/_____
Applicant Social Security # _____-_____-_____
Applicant Medical Record # _____

Name of Spouse_____
Spouse Birthdate_____/_____/_____
Spouse Social Security #_____-_____-_____
Spouse Medical Record #_____

MONTHLY NET INCOME	AMOUNT	MONTHLY EXPENSES	AMOUNT	ASSETS	ACCOUNT TYPE & NUMBER	AMOUNT
Net Wages (after taxes)	$	**Home:**		**Bank Name**	**Type: Checking, savings, money market, CD account, retirement, etc.**	N/A
		Mortgage	$			
		Insurance	$			
		Taxes	$	(e.g. Bank of America)	(e.g. Checking Acct-11111-34567)	
Rent (income)	$	Rent (expense)	$			$
Self-Employment	$	Food	$			$
Unemployment (EDD)	$	Utilities	$			$
Workers' Comp	$	Clothing	$	Cash on Hand	Not Applicable (N/A)	$
Public Assistance:		**Auto:**		**Investments:**		
General Assistance	$	Payments	$	Stocks		$
CalWorks	$	Insurance	$	Bonds		$
Other	$	Gas	$	Treasury Bills		$
		Maintenance	$	Other Securities		$
Social Security Disability	$	Public Transportation	$	OTHER ASSETS	ADDITIONAL INFORMATION	AMOUNT
Retirement Income:		**Healthcare:**		**Automobiles:**	Make, Model, Year	
Social Security	$	Clinic visits	$	Vehicle #1		
Pension	$	Prescriptions	$	Vehicle #2		N/A
Other	$	Insurance premiums	$	Vehicle #3		
		Co-pays	$	Vehicle #4		
State Disability	$	Childcare Cost (or other Dependant Care)	$	Life Insurance (Cash Surrender Value)	Policy Number:	$
Child Support (income)	$	Child Support (expense)	$	**Real Estate Property:**	Lender, Account # and Loan Amount	Loan Balance
Alimony (income)	$	Alimony (expense)	$	Address #1		$
Financial Assistance (family or friends)	$	Life Insurance Premium	$			
Investments:		Credit Card Payments		Address #2	Lender, Account # and Loan Amount	Loan Balance
Dividends	$	Name, Acct #				$
Interest	$		$			
Annuity	$		$			
Other	$		$			
Other (Specify)		Other (Specify)		Other (Specify)		
	$		$			$
	$		$			$
	$		$			$
	$		$			$
Total Net Income	$	**Total Expenses**	$	**Total Assets**	N/A	$

1. If your expenses this month are more than your income, how are you paying the difference (savings account, loan, help from someone else, etc.)? You will need to bring in the following applicable documentation to show how you paid the difference: bank statements, a letter from the person who is helping you, or other documentation.

_____

_____

_____

Documents provided: _____

2. If you are not able to pay all of your expenses this month, which expenses are you not able to pay? You will need to bring in the following applicable documentation which shows that you do not have enough money to pay your monthly expenses: bank statements, overdue bills, receipts showing you only paid part of a bill, or other documentation.

_____

_____

_____

Documents provided: _____

3. My plan to meet next month's expenses is _____

_____

4. If you owe money, please write down the total amounts of all outstanding debt.

Credit Cards	$_____	Car Loans	$_____
Bills	$_____	Property Loans	$_____
Child Support	$_____	Other	$_____

5. Please add any other information about your financial situation.

_____

_____

_____

I declare under penalty of perjury that the above information is true and correct. Further, by signing below, I hereby authorize County personnel, agents or contractors, to verify and/or investigate my eligibility. Such investigation/verification may include the obtaining and use of information and documents possessed by other public and private agencies, including, but not limited to, records of the Department of Child Support Services. If, upon investigation, it is determined that I am not eligible for the Financial Assistance Program based on income, assets or residency, I will be notified and enrolled in the financial assistance program for which I am eligible.

_____	_____	_____/_____/_____
Patient/Guarantor Signature	Staff Signature	Date