UNIVERSITY MEDICAL CENTER

Financial Assistance Questionnaire

Name: ____ Marital Status ____________________

Complete Address: ____ Phone: _______________

Social Security # ___________________ UMC account # (if available) _____________________

Do you have any kind of health insurance? Yes_____ No_____

If yes, please send us a copy of your insurance card or other proof of coverage so we can bill it appropriately.

Household Members

List only your spouse and your natural or adopted children that are under the age of 18 who reside with you.

Name: _____________________________ Age: ________ Relationship: ____________________

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Name: _____________________________ Age: ________ Relationship: ____________________

(use a separate sheet of paper if household members exceed six)

Gross Income (Before Taxes)

What is the total gross income for yourself and all members listed above? $__________________

Expenses

Rent/Mortgage: $_______________

Assets

Do you own a primary residence or other property? Yes_____ No_____

If yes, what is the value of all properties? $____________

Do you have checking or savings accounts? Yes_____ No_____

If yes, what is the balance of all accounts? $________________

I understand that the above information is for statistical information only and that I may be asked for documented proof of income, expenses and assets listed above. I understand that as per the Financial Assistance Policy, assistance under this questionnaire is available only to uninsured individuals.

____ _________________________

Signature Date