PATIENT FINANCIAL ASSESSMENT REQUEST FORM

Tri-City Medical Center

Date:_____

PATIENT NAME: LAST	FIRST	MIDDLE
PATIENT ADDRESS:		MEDICAL RECORD #
CITY, STATE & ZIP	PATIENT SOCIAL SECURITY #	FAMILY SIZE (REQUIRED)
MAIDEN NAME OR OTHER:		PHONE #: ( )
NEXT OF KIN NAME:	PHONE #: ( )	WORK PHONE ( )
EMERGENCY PHONE	PATIENT DOB	CELL PHONE:# ( )

RESPONSIBLE PARTY		SPOUSE	
NAME	OCCUPATION	NAME	OCCUPATION
EMPLOYER (IF SELF EMPLOYEE DESCRIBE)	SOCIAL SECURITY #	EMPLOYER (IF SELF EMPLOYEE DESCRIBE)	SOCIAL SECURITY #
ADDRESS		ADDRESS	
SUPERVISOR NAME		SUPERVISOR NAME	
PHONE	YEARS	PHONE	YEARS
INCOME (REQUIRED) $_____ ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY		INCOME (REQUIRED) $_____ ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY	

ASSETS	LIABILITIES
CASH ON HAND ..... $_____	REAL ESTATE PAYMENTS ..... $_____
CHECKING ACCOUNT ..... $_____	INSURANCE PREMIUMS (AUTO/MED/HOME) ..... $_____
SAVINGS ACCOUNT ..... $_____	TAXES ..... $_____
CREDIT UNION ACCOUNT ..... $_____	UTILITIES ..... $_____
PROPERTY OWNED VALUE ..... $_____	AUTO PAYMENTS ..... $_____
MOTOR VEHICLES OWNED ..... $_____	FOOD ..... $_____
MAKE: _____ YEAR _____	HOUSE PAYMENT IF RENTING .... $_____
MAKE: _____ YEAR _____	OTHER LIABILITIES: (ATTACH SEPARATE SHEET IF NECESSARY)
HOME OWNER ESTIMATED VALUE ..... $_____	DESCRIBE / PAYMENT / BALANCE
OTHER SOURCES/ (STOCK BONDS) ..... $_____	_____ _____ _____
	_____ _____ _____

BANK BRANCH(S) & ACCOUNT NUMBERS

I/WE HEREBY DECLARE THE FOREGOING TO BE TRUE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA.

_____ _____

SIGNATURE(S) DATE

FOR PA USE ONLY

350% FPL_____ APPROVED: ☐ YES ☐ NO BY WHOM: _____

IF PARTIAL AMOUNT: $_____

Rev (3/16)