SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

FINANCIAL ASSISTANCE APPLICATION

VMC Medical Record Number: _____

PATIENT INFORMATION

1. Resident of Santa Clara County? □ Yes / □ No	2. Gender □ M / □ F	3. Legal Name (*Last, First, Middle*)	4. Mother's Maiden Name	5. Spouse / Domestic Partner	6.Preferred Language?
7. Address Zip	8. Phone 1) (_____) _____ 2) (_____) _____		9. Email Address		
10. SSN (PATIENT) _____ - _____ - _____	11. SSN (SPOUSE / DOMESTIC PARTNER) _____ - _____ - _____	12. U.S. Citizen? □ Yes / □ No	13. Have permanent residency status? □ Yes / □ No If yes, How long? Length:_____ Years_____ Months_____	14. U. S. Veteran? □ Yes / □ No	

FAMILY HOUSEHOLD STATUS

15. List the names of all members in your household and family, and their relationship to you. Please Add yourself. Please check the box (□) if you claim him/her on tax return form.

NAME	Date of Birth (Month/Day/Year)	RELATION	NAME	Date of Birth (Month/Day/Year)	RELATION
(□)	/ /		(□)	/ /	
(□)	/ /		(□)	/ /	
(□)	/ /		(□)	/ /	

MOST RECENT EMPLOYMENT AND OCCUPATION

16. Patient's Employer:	17. Contact Phone Number (_____) _____-_____	18. If Self-Employed, Name of Business
19. Spouse's Employer:	20. Contact Phone Number (_____) _____-_____	21. If Self-Employed, Name of Business

22. Start Date: _____/_____/_____ 23. End Date: _____/_____/_____ 24. Job is Current: □ Yes / □ No 25. Have a Disability expected to last at least 12 months? □ Yes / □ No

INSURANCE COVERAGE INFORMATION

26. Have Health Insurance: □ Yes / □ No Name of Insurance:	Insurance Contact Number: (_____) _____-_____	27. Were your injuries caused by a third party (such as during a car accident or slip and fall)? □ Yes / □ No	28. Have other insurance that may apply (such as an auto policy)? □ Yes / □ No

CURRENT MONTHLY INCOME

	Monthly Income Sources	Patient	Spouse	Other
29a)	**GROSS** PAY *(tax & other deductions)*	$	$	$
29b)	Income from Operating Business (if Self-Employed)	$	$	$
29c)	Other Income:	$	$	$
29d)	Interest and Dividends	$	$	$
29e)	From Real Estate or Personal Property	$	$	$
29f)	Social Security	$	$	$
29g)	Other (specify):	$	$	$
29h)	Alimony or Support Payments Received	$	$	$
29i)	Add the amounts in the right column from line (29a) through (29h)	$	$	$
29j)	Alimony or Support Payments Paid	$	$	$
29k)	Subtract line (29j) from line (29i). This is your Current Monthly Income.	$	$	$
29l)	**TOTAL INCOME FROM ALL COLUMNS line 29k** →	**$**		

30. Do you have a Primary Care Physician (PCP) at a community clinic?
If Yes. What is the name of your PCP (Primary Care Physician)? _____
Do you have a Primary Care Physician (PCP) at VMC?
If Yes. What is the name of your PCP (Primary Care Physician)? _____ .

For Office Use Only

Total Income Gross: _____

Frequency

□ Weekly □ Bi-Weekly

□ Semi-Monthly □ Monthly

Family Size: _____ Final FPL: _____

SIGNATURE

I certify under penalty of perjury by my signature that the information I have provided as required in this agreement is true and complete to the best of my knowledge and belief. I am fully responsible to inform SCVHHS and any programs for which I may be eligible, including, but not limited to, the various Medication Assistance Programs, of any change in my residency, financial status, and/or third party coverage. I also certify by my signature that I have read and understand all the foregoing and that I agree to have Medication Assistance Program staff act on my behalf for all eligible medications. I give my consent to release my information to Pharmaceutical Companies for auditing purposes in the Bulk Replacement Patient Assistance as well as to Santa Clara County Social Services Agency (SCCSSA) for the purpose of determining eligibility for Medi-Cal, and authorize SCCSSA to provide information on my Medi-Cal Status. I certify that all information is valid and complete and authorize SCVHHS to request a credit report and /or to verify any of the above information as deemed necessary.

SIGNATURE _____ **Date** _____