Marin Healthcare District
Medical Care Centers

FINANCIAL ASSISTANCE PROGRAM

P: 1-415-493-3318

STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____

ADDRESS _____

ACCOUNT NUMBER(S) _____

SPOUSE _____

PHONE _____ SSN _____

FAMILY STATUS (List all dependents that you support)

NAME	*AGE*	*RELATIONSHIP*

EMPLOYMENT AND OCCUPATION

EMPLOYER _____

POSITION _____

CONTACT PERSON & TELEPHONE _____

IF SELF EMPLOYED, NAME OF BUSINESS _____

SPOUSE'S EMPLOYER _____

SPOUSE'S POSITION _____

SPOUSE'S CONTACT PERSON & TELEPHONE _____

IF SELF EMPLOYED, SPOUSE'S NAME OF BUSINESS _____

CURRENT MONTHLY INCOME (Add gross pay before tax/deductions)

	PATIENT	*SPOUSE*
ADD OTHER INCOME	_____	_____
INTEREST % DIVIDENDS FROM REAL ESTATE/PROPERTY	_____	_____
SOCIAL SECURITY	_____	_____
OTHER (PLEASE SPECIFY)	_____	_____
ALIMONY, SUPPORT PAYMENTS RECEIVED	_____	_____
SUBTRACT	_____	_____
ALIMONY, SUPPORT PAID OUT	_____	_____
EQUALS	A _____	B _____

TOTAL INCOME _____ (A+B)

FAMILY SIZE

ADD PATIENT, SPOUSE, & DEPENDENTS FROM ABOVE _____

PATIENT:
ARE YOU INSURED? YES NO IF YES, PLEASE INDICATE _____

DO YOU HAVE OTHER INSURANCE THAT MAY APPLY? (IE. AUTO POLICY) YES NO IF YES, PLEASE INDICATE _____

WERE YOUR INJURIES CAUSED BY A THIRD PARTY?
(IE. CAR ACCIDENT, SLIP & FALL) YES NO IF YES, PLEASE INDICATE _____

_____ _____

PATIENT SIGNATURE **SPOUSE SIGNATURE**

DATE _____