

**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: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

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