California Rehabilitation INSTITUTE
A Cedars/UCLA Health Partnership

Financial Assistance Application Form

SECTION ONE: PATIENT INFORMATION

Print your full name, your address at the time you received medical service and other information noted in this section.

Account Number ______________________ Date(s) of Service ______________________

Patient Name: ______________________
LAST FIRST MIDDLE INITIAL

Address: ______________________ City: ______________ County: ______________
NUMBER AND STREET

State of Residence: ______________ Zip Code: ______________ Date of Birth: _____/_____/_____ Marital Status: q Single q Married q Divorced

Primary Phone Number: (__________) ______________ q Home q Mobile q Work q Other ______________

Email Address: ______________________

Health insurance at time of date of service: q No Insurance q Medicare q Medicaid q Other ______________

SECTION TWO: FAMILY INCOME AND ASSETS

Provide income for yourself, your spouse and all other family members (if applicable).

Income Source	Total for 3 Months Prior to Service	Total for 12 Months Prior to Service
Wages/Self Employment	$	$
Social Security	$	$
Pension, Dividends, Interest, Rental Income	$	$
Unemployment, Workers' Compensation	$	$
Child Support (only if the patient is the intended recipient)	$	$
Other	$	$

Total Net Assets (Assets - Debt) as if the Date of Application: $______________________

SECTION THREE: FAMILY INFORMATION AND INCOME

List all family members and their date of birth.

Please provide the following information for all of the people in your family. Family is defined for patients 18 years of age and older as their spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not. For patients under 18 years of age or for a dependent child 18 to 20 years of age, "Family" is inclusive of parents, caretaker relatives and parent's or caretake relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.

Name of family members, including patient | Date of Birth | Relationship to Patient

1. Patient: ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

By my signing below, I certify that everything I have stated on this application and on any attachments is true.

Responsible Party Signature: x ______________________ Date: ______________

By my signing below, I certify that I have reviewed and approve this application.

Hospital CEO Signature: x ______________________ Date: ______________

Return your completed application to: **California Rehabilitation Institute**

2070 Century Park East Los Angeles, CA 90067 (424)522-7100

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