Financial Assistance Application

UCSF Benioff Children's Hospital
Pediatric Multiple Sclerosis Center

1. PATIENT INFORMATION				
Last Name	**First Name**	**Initial**	**Account Number**	**Med. Record No.**

2. APPLICANT INFORMATION					**RELATIONSHIP TO PATIENT** ☐ Self ☐ Spouse ☐ Parent ☐ Other _____
Last Name	**First Name**	**Initial**	**Social Security Number**		**U.S. Citizen** ☐ Yes ☐ No
Date of Birth	**No. of Dependents** (other than self & spouse)		**Ages of Dependents**		**Home Phone** ( )
Street Address (Do Not List PO Box)	**City**	**State**	**County**	**Zip**	
Current Employer	**Street Address, City, State**		**Position**		

3. CO-APPLICANT INFORMATION					**RELATIONSHIP TO PATIENT** ☐ Self ☐ Spouse ☐ Parent ☐ Other _____
Last Name	**First Name**	**Initial**	**Social Security Number**		**U.S. Citizen** ☐ Yes ☐ No
Date of Birth	**No. of Dependents** (don't include those claimed by spouse)		**Ages of Dependents**		**Home Phone** ( )
Street Address (Do Not List PO Box)	**City**	**State**	**County**	**Zip**	
Current Employer	**Street Address, City, State**		**Position**		

4. INCOME INFORMATION **(To document additional income, use back of this application)**				**Combined Monthly Income**
	Monthly Income Sources	**Applicant**	**Co-Applicant**	
	Employment Income	$	$	$
	Social Security	$	$	$
	Alimony/Child Support	$	$	$
	Other (List on back of page)	$	$	$
		Total Combined Monthly Income		$

5. ASSETS **(To document additional assets, use back of this application)**

Checking/Money Market/Savings Accounts:

Bank Name:	Branch/Address	Account Number	Monthly Balance/ Value
1.			$
2.			$
Other Assets:			$
	Total Asset Value		$

6. SUPPORTING DOCUMENTATION

This application cannot be processed unless UCSF Medical Center is provided the information listed below as proof of income and that you give answers as completely as possible to the questions of this form:

From both applicant & co-applicant
Copies of one month worth of pay stubs for both applicant & co-applicant.
Current year's W-2 earnings statements for both applicant & co-applicant

7. COMMENTS

8. SIGNATURE

I certify that all information is valid and complete and hereby authorize UCSF Medical Center to request a credit check report and/or verify any of the above information as deemed necessary.

Applicant **Date** **Co-Applicant** **Date**

_____ _____