CANCER RESEARCH & LIFE FOUNDATION

FINANCIAL EVALUATION FORM

Country of Resident:	Healthcare Insurance Information:	Account/Medical Record Number

Please provide the following information completely and accurately. Information is subject to verification.
Please attach a list of additional Household members if there are more than five (5) members.

Patients Name:	Social Security Number:	Total # of Household Members:
Address:	Telephone Numbers: Home: ( ) Work: ( )	
City/State/Zip:	Employer: (Patient/Responsible Party)	

LIST ALL HOUSEHOLD MEMBER NAMES	DATE OF BIRTH	SOC. SECURITY NUMBER	RELATIONSHIP TO PATIENT	MONTHLY INCOME
1.		- -		$
2.		- -		$
3.		- -		$
4.		- -		$
5.		- -		$

MONTHLY INCOME		MONTHLY EXPENSES	
Responsible Party's Gross Income (before taxes)	$	Rent/Mortgage/Homeowner's Insurance	$
Other household Gross Income (before taxes)	$	Utilities (Electricity/Water/Gas)	$
Investment Income (Annuities/Stocks/Dividends)	$	Telephone	$
Child Support/Alimony Received	$	Child Support/Alimony Paid	$
Rental Property Income	$	Car Payment (loan + insurance)	$
Pension/Retirement/Unemployment	$	Medical & Pharmacy Bills	$
Other:	$	Food (excluding cigarettes & alcoholic beverages)	$
Total Monthly Income (before Taxes)	$	**Total Monthly Expenses**	$

ASSETS		LIABILITIES	
Value of Residence(s)	$	Residence Loan Balance/Mortgage	$
Checking Account Balance	$	Balance Owed on Credit Cards	$
Savings/Money Market/CD's/Retirement Funds	$	Auto Loan Balance	$
Value-Auto/Boat/Motorcycle	$	Total Medical Bills (attach list)	$
Other:	$	Real Estate Taxes	$
Total Value of Assets	$	**Total Liabilities**	$

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is no additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through Orange Coast Medical Center of Hope. If I am entitled to an action against or settlement from third party payers, I will take any action necessary or requested by OCMCOH to obtain such assistance and will assign to OCMCOH, and upon receipt, will pay to OCMCOH, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by OCMCOH will result int the denial of this application. I also authorize OCMCOH to check my credit history through the credit bureau, if deemed appropriate.

_____ _____

Signature of Patient (Responsible Party) Date