VCMC Ventura County Medical Center

Account # _____

Associated with the UCLA School of Medicine

Division of the Ventura County Health Care Agency

30 DAY NOTICE

Date: _____

Patient: _____ Due Date: _____

It is necessary that you return the following checked items within 30 days.
If you need to see me, please call for an appointment.

_____ _____

Financial Representative Telephone Number

____ Driver's License/Identification Card

____ Social Security Card

____ Alien Status Card/Papers

____ Last 4 Pay Check Stubs

____ Unemployment/Disability Checks

____ Social Security Check/Award Letter

____ Child Support Paid or Received

____ Last Income Tax Filed

____ Other Income: _____

____ Free Room & Board Statement

____ Savings - Statement from Bank

____ Checking - Statement from Bank

____ Car Payment Receipts

____ Mortgage/Rent Receipts

____ Charge Card Statements

____ Other: _____

_____

_____

_____

_____

_____

_____

_____

_____

Patient's Signature: _____

3291 Loma Vista Road • Ventura, California 93003 • (805) 654-3306

HEALTH CARE AGENCY · VENTURA COUNTY

FINANCIAL STATEMENT

PATIENT'S NAME	ACCOUNT NUMBER
ADDRESS	PHONE NUMBER

Do you have Medi-Cal? ☐ Yes ☐ No Medi-Care? ☐ Yes ☐ No Health Insurance? ☐ Yes ☐ No

MAN		WOMAN	
NAME		NAME	
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH
DRIVER'S LICENSE NUMBER	ALIEN REGISTRATION NUMBER	DRIVER'S LICENSE NUMBER	ALIEN REGISTBATION NUMBER

MAN'S EMPLOYMENT		WOMAN'S EMPLOYMENT	
EMPLOYER		EMPLOYER	
ADDRESS		ADDRESS	
TYPE OF JOB	HOW LONG EMPLOYED?	TYPE OF JOB	HOW LONG EMPLOYED?
WORKING NOW? ☐ Yes ☐ No	GROSS SALARY $____ week/month	WORKING NOW? ☐ Yes ☐ No	GROSS SALARY $____ week/month
NET SALARY $____ week/month		NET SALARY $____ week/month	

Other Income: $ ____ Type ____ Other Income: $ ____ Type ____

Deductions: Federal Income Tax $ ____ State Income Tax $ ____ SDI $ ____

Social Security $ ____ Retirement$ ____ Health Insurance $ ____

ASSETS

NAME OF BANK	ADDRESS		
CHECKING $____	ACCOUNT NUMBER	SAVINGS $____	ACCOUNT NUMBER
VEHICLES: MAKE AND YEAR	OTHER VEHICLES OR BOATS	HOUSE PAYMENT OR RENT $____	
NO. OF DEPENDENT CHILDREN	AGES	STOCKS, BONDS $____	
REAL ESTATE (Cash Value) $____	ADDRESS		
LIFE INSURANCE (Cash Value) $____	AGENCY		

By signing this document I give the Health Care Agency authorization to verify any information contained on this form and to obtain any other information to determine my financial liability.

I declare under penalty of perjury the information contained on this form is true and correct.

SIGNATURE	DATE	INFORMATION TAKEN BY	DATE
Payment and Security Signed: ☐ Yes ☐ No		INFORMATION VERIFIED BY	DATE