Sonoma Valley Hospital – Financial Assistance Application
(Charity Care and Discount Payment / Payment Plan Programs)

HELP PAYING YOUR HOSPITAL BILL

Sonoma Valley Hospital offers **Financial Assistance** to patients who cannot afford medically necessary hospital services. Assistance is available to ALL, regardless of immigration status.

Please select the program you are applying for:
☐ Charity Care (Free Care – 100% Write-Off)
☐ Discount Payment / Payment Plan

Note: Patients may apply for both programs if eligible. Each program has separate eligibility and documentation requirements.

PATIENT INFORMATION

Patient Name: _____
Account Number(s): _____
Medical Record Number (MRN): _____
Guarantor Number (if applicable): _____
Address: _____
City / State / ZIP: _____
Phone Number: _____

HOUSEHOLD INFORMATION

Household Size: _____
(Include yourself, spouse/domestic partner, and tax-dependent children)

List dependents claimed on your most recent tax return:

Name Age Relationship

(Attach additional pages if needed.)

EMPLOYMENT INFORMATION

Patient Employer: _____
Position: _____

Spouse / Domestic Partner Employer: _____
Position: _____

HOUSEHOLD INCOME INFORMATION

Please list **current gross monthly household income** for all adult household members:

1. Wages / salary: _____
2. Self-employment / business income: _____
3. Social Security / disability / retirement: _____
4. Other income (specify): _____

Total Monthly Household Income: _____

REQUIRED DOCUMENTATION

Charity Care Applicants:

- Provide **one** of the following for all adult household members:
  - Recent paystubs (within 6 months before or after first billing date)
  - Most recent federal income tax return (for calendar year of first bill or 12 months prior)
  - Signed statement explaining how households are financially supported (if no tax filing)

Discount Payment Applicants:

- Provide **one** of the following for all adult household members:
  - Recent paystubs (within 6 months before or after first billing date)
  - Most recent federal income tax return (for calendar year of first bill or 12 months prior)
- The hospital will not require multiple documents unless necessary to clarify conflicting information.

PAYMENT PLAN INFORMATION (Discount Payment Only)

- The hospital will negotiate payment plan terms based on **household income** and **essential living expenses**.
- If an agreement cannot be reached, a **reasonable payment plan** will be offered where monthly payments do **not exceed 10% of the monthly household income** (excluding essential living expenses).

CERTIFICATION

I certify that the information provided is complete and accurate. I understand Sonoma Valley Hospital may request additional documentation to determine eligibility. Submitting this application **does not guarantee approval**.

Patient or Guarantor Signature: _____ Date: _____
Spouse / Domestic Partner Signature: _____ Date: _____

SUBMISSION

Sonoma Valley Hospital – Patient Accounting / Financial Assistance
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