Sutter Health

SUTTER HEALTH CHARITY CARE AND DISCOUNT PAYMENT APPLICATION

APPLICATION FOR FINANCIAL ASSISTANCE (Non-NHCS Clinics)

PATIENT NAME_____

SPOUSE_____

ADDRESS_____

PHONE_____

ACCOUNT#_____

SNN _____ _____
(PATIENT) (SPOUSE)

FAMILY STATUS: List the members of the patient's family. For patients 18 years or older (except for a dependent child 18 to 20 years of age), family includes the Patient's spouse, registered domestic partner, and dependent children under 21, or a dependent child of any age if disabled, 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 includes Patient's parent, caretaker relatives, and other dependent children under 21 years of age, or any age if disabled, of the parent or caretaker.

Name	Age	Relationship

EMPLOYMENT AND OCCUPATION

Employer:_____

Position:_____

Contact Person & Telephone:

_____

If Self-Employed, Name of Business:

_____

Spouse Employer:_____

Position:_____

Contact Person & Telephone:

_____

If Self-Employed, Name of Business:

_____

CURRENT MONTHLY INCOME

	Patient	**Other family income, including spouse**
Gross pay (before deductions)		
Add: Income from operating business (if self employed)		
Add: Income from interest and dividends		
Add: Income from real estate or personal property		
Add: Social security		
Add: Other income (specify)		
Add: Alimony or support payments received		
Subtract: Alimony, support payments paid		
***Equals:* Current Monthly Income (patient + other family, including spouse).**		

FAMILY SIZE

Total Number of Family Members _____
(Add patient, parents (for minor patients), spouse and children from above)

	Yes	No
Do you have health insurance?	☐	☐
Do you have other Insurance that may apply (such as an auto policy)?	☐	☐
Were your injuries caused by a third party (such as during a car accident or slip and fall)?	☐	☐

By signing this form, I agree to allow Sutter Health to check employment for the purpose of determining my eligibility for a financial discount, I understand that I may be required to provide proof of the information I am providing in the form of recent pay stubs or tax returns. Sutter Health will consider other forms of proof of income if submitted, though other forms of proof of income are not required.

_____ _____
(Signature of Patient or Guarantor) (Date)

_____ _____
(Signature of Spouse) (Date)

Sutter Health

APPLICATION FOR FINANCIAL ASSISTANCE (NHSC Clinic)

PATIENT NAME_____

SPOUSE_____

ADDRESS_____

PHONE_____

ACCOUNT#_____

SNN _____ _____
(PATIENT) (SPOUSE)

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Position:_____

Contact Person & Telephone:

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If Self-Employed, Name of Business:

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Spouse Employer:_____

Position:_____

Contact Person & Telephone:

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If Self-Employed, Name of Business:

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