

APPLICATION FOR FINANCIAL ASSISTANCE (Non-NHCS Clinics)

PATIENT NAME _____ SPOUSE _____
ADDRESS _____ PHONE _____
ACCOUNT# _____ SSN _____
(PATIENT) (SPOUSE)

FAMILY STATUS: List any spouse, domestic partner, or children under the age of 21. If patient is a minor, list all parents, caretaker relatives, and siblings under 21

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

<i>Add:</i>	Gross Pay (before deductions)		
<i>Add:</i>	Income from Operating Business (if Self-Employed)	_____	_____
<i>Add:</i>	Other Income:		
	Interest and Dividends	_____	_____
	From Real Estate or Personal Property	_____	_____
	Social Security	_____	_____
	Other (specify):	_____	_____
	Alimony or Support Payments Received	_____	_____
<i>Subtract:</i>	Alimony, Support Payments Paid	_____	_____
<i>Equals:</i>	Current Monthly Income	_____	_____
	Total Current Monthly Income (add Patient + Spouse)	_____	_____
	Income from above	_____	_____

FAMILY SIZE

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

	Yes	No
Do you have health insurance?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have other Insurance that may apply (such as an auto policy)?	<input type="checkbox"/>	<input type="checkbox"/>
Were your injuries caused by a third party (such as during a car accident or slip and fall)?	<input type="checkbox"/>	<input type="checkbox"/>

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.

(Signature of Patient or Guarantor) (Date)

(Signature of Spouse) (Date)

APPLICATION FOR FINANCIAL ASSISTANCE (NHSC Clinic)

PATIENT NAME _____ SPOUSE _____
ADDRESS _____ PHONE _____
ACCOUNT# _____ Social Security Number _____
(PATIENT) (SPOUSE)

FAMILY STATUS: List any spouse, domestic partner, or children under the age of 21. If patient is a minor, list all parents, caretaker relatives, and siblings under 21

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
Gross Pay (before deductions)		
Add: Income from Operating Business (if Self-Employed)	_____	_____
Add: Other Income:		
Interest and Dividends	_____	_____
From Real Estate or Personal Property	_____	_____
Social Security	_____	_____
Other (specify):	_____	_____
Alimony or Support Payments Received	_____	_____
Subtract: Alimony, Support Payments Paid	_____	_____
Equals: Current Monthly Income	_____	_____
Total Current Monthly Income (add Patient + Spouse)	_____	_____
Income from above	_____	_____

FAMILY SIZE

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

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