APPLICATION FOR FINANCIAL ASSISTANCE

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
	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)

	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 financing discount, I understand that I may be required to provide proof of the information I am providing.

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

_____ _____
(Signature of Spouse) (Date)

FINANCIAL ASSSISTANCE CALCULATION WORKSHEET

Patient Name: _____ Patient Account #: _____
Sutter Health Affiliate: _____

Special Considerations/Circumstances: _____

_____

	Yes	No
Does Patient have Health Insurance?	☐	☐
Is Patient Eligible for Medicare?	☐	☐
Is Patient Eligible for Medi-Cal/Medicaid?	☐	☐
Is Patient Eligible for Other Government Programs (i.e. Crime Victims, etc.)?	☐	☐

If the patient applies, or has a pending application, for another health coverage program at the same time that he or she applies for a charity care or discount payment program, neither application shall preclude eligibility for the other program.

Does Patient have other insurance (i.e. auto medpay)?	☐	☐
Was Patient inured by a third party?	☐	☐
Is Patient Self-Pay?	☐	☐

Charity/Financial Assistance Calculation:

Total Combined Current Monthly Income
(From Statement of Financial Condition) $ _____

Family Size (From Statement of Financial Condition) _____

Qualification for Charity Care/Financial Assistance (circle one): Full/High Medical Cost/Catastrophic

(Identify using eligibility guide) No Eligibility

Catastrophic Charity Write-off Calculation (complete section only if patient qualifies for catastrophic charity w/o):

A. Patient Liability (total charges unless another discount has been applied) $ _____

B. Annual Income $ _____

C. Patient Liability as Percent of Annual Income. $ _____

D. Is Line A divided by Line B greater than .30 (30%)? Yes ☐ No ☐

E. If no, patient is not eligible for this type of write-off $ _____0_____

F. If yes, multiply Line B by 30 % to identify the patient liability amount $ _____

G. If yes, Subtract line F from Line A to identify the write-off amount. $ _____

Total Amount of Recommended Charity Write-offs(s): $ _____

Worksheet Completed by: _____ **Phone:** _____

Approved by: _____ **Date:** _____

NOTIFICATION FORM
MOUNTAIN COMMUNITIES HEALTHCARE DISTRICT - TRINITY HOSPITAL
ELIGIBILITY DETERMINATION FOR FINANCIAL ASSISTANCE

Trinity Hospital has conducted an eligibility determination for financial assistance for:

_____	_____	_____
PATIENTS NAME	ACCOUNT NUMBER	DATE(S) OF SERVICE

The request for financial assistance was made by the patient or on behalf of the patient on _____ .
This determination was completed on_____ .

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:
Your request for financial assistance has been approved for services rendered on _____

After applying the financial assistance reduction, the amount owed is $_____ .

Your request for financial assistance is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____
_____
_____

Your request for financial assistance has been denied because:
REASON: _____
_____
_____

Granting of financial assistance is conditioned on the completeness and accuracy of the information provided to the hospital. In the event the hospital discovers you were injured by another person, you have additional income, you have additional insurance or provided incomplete or inaccurate information regarding your ability to pay for the services provided, the hospital may revoke its determination to grant Financial Assistance and hold the you and/or third parties responsible for the hospital's charges.

If an application has been submitted for another health coverage program at the same time that you submit an application for Financial Assistance, neither application shall preclude eligibility for the other program.

If you have any questions on this determination, please contact: Marilyn Fegley, Financial Counselor at 530-623-5541 ext)3217. If you have a dispute regarding this determination, please contact Kelly Simpson, Director of Revenue Cycle at 530-623-5541 ext)3258