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
	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 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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(Signature of Patient or Guarantor) (Date)

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