Santa Rosa Behavioral Healthcare Hospital
Kindness, Service, Healing

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME _____ SPOUSE_____
ADDRESS _____ PHONE_____

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)?	☐	☐

When applying only for discount payment program eligibility, Santa Rosa Behavioral Healthcare Hospital may only request recent paystubs or income tax returns for documentation of income. Other forms of documentation of income may be requested, but may not require them. Patients applying only for discount payment program eligibility may receive less financial assistance than what may be available under our charity care program.

By signing this form, I agree to allow Santa Rosa Behavioral Healthcare Hospital 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. Santa Rosa Behavioral Healthcare Hospital will consider other forms of proof of income if submitted.

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

_____ _____
(Signature of Spouse) (Date)