



**Sonoma Valley Hospital – Financial Assistance Application  
(Charity Care and Discount Payment / Payment Plan Programs)**

**HELP PAYING YOUR HOSPITAL BILL**

Sonoma Valley Hospital offers **Financial Assistance** to patients who cannot afford medically necessary hospital services. Assistance is available to ALL, regardless of immigration status.

**Please select the program you are applying for:**

- Charity Care (Free Care – 100% Write-Off)
- Discount Payment / Payment Plan

**Note:** Patients may apply for both programs if eligible. Each program has separate eligibility and documentation requirements.

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_

Account Number(s) \_\_\_\_\_

Medical Record Number (MRN): \_\_\_\_\_

Guarantor Number (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

City / State / ZIP \_\_\_\_\_

Phone Number: \_\_\_\_\_

**HOUSEHOLD INFORMATION**

Household Size: \_\_\_\_\_

Include yourself, spouse/domestic partner, parents, caretakers, tax-dependent children, etc.

**List dependents claimed on your most recent tax return:**

## Name Age Relationship

(Attach additional pages if needed.)

## EMPLOYMENT INFORMATION

Patient Employer: \_\_\_\_\_  
Position: \_\_\_\_\_

Spouse / Domestic Partner Employer: \_\_\_\_\_

Position: \_\_\_\_\_

## HOUSEHOLD INCOME INFORMATION

Please list **current gross monthly household income** for all adult household members:

1. Wages / salary: \_\_\_\_\_
2. Self-employment / business income: \_\_\_\_\_
3. Social Security / disability / retirement: \_\_\_\_\_
4. Other income (specify): \_\_\_\_\_

**Total Monthly Household Income:** \_\_\_\_\_

## REQUIRED DOCUMENTATION

### Charity Care Applicants:

- Provide **one** of the following for all adult household members:
  - Recent paystubs (within 6 months before or after first billing date)
  - Most recent federal income tax return (for calendar year of first bill or 12 months prior)
  - Signed statement explaining how households are financially supported (if no tax filing)

### Discount Payment Applicants:

- Provide **one** of the following for all adult household members:
  - Recent paystubs (within 6 months before or after first billing date)
  - Most recent federal income tax return (for calendar year of first bill or 12 months prior)

- The hospital will not require multiple documents unless necessary to clarify conflicting information.

**PAYMENT PLAN INFORMATION (Discount Payment Only)**

- The hospital will negotiate payment plan terms based on **household income** and **essential living expenses**.
- If an agreement cannot be reached, a **reasonable payment plan** will be offered where monthly payments do **not exceed 10% of the monthly household income** (excluding essential living expenses).

**CERTIFICATION**

I certify that the information provided is complete and accurate. I understand Sonoma Valley Hospital may request additional documentation to determine eligibility. Submitting this application **does not guarantee approval**.

Patient or Guarantor Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Spouse / Domestic Partner Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**SUBMISSION**

Sonoma Valley Hospital – Patient Accounting / Financial Assistance  
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