Exhibit B
APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME _____ SPOUSE _____
ADDRESS _____ PHONE_____
ACCOUNT# _____ SNN _____ _____
(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)

Exhibit C
FINANCIAL ASSSISTANCE CALCULATION WORKSHEET

Patient Name: _____ Patient Account #: _____
Hospital: _____

Special Considerations/Circumstances: _____
_____
_____
_____

	Yes	No
Does Patient have Health Insurance?	❑	❑
Is Patient Eligible for Medicare?	❑	❑
Is Patient Eligible for Medi-Cal?	❑	❑
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 hospital 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??	❑	❑

Financial Assistance Calculation:
Total Combined Current Monthly Family Income (From Application for Financial Assistance) $_____

Family Size (From Application for Financial Assistance) _____

Qualification for Financial Assistance Met Yes No