Financial Assistance Program For Low Income Uninsured Patients
Frequently Asked Questions

How do I determine whether I qualify for financial assistance for my hospital bills?

Sonoma Valley Hospital offers Charity Care Discount Payment options to our low-income, uninsured patients that meet the program eligibility requirements. Using the most recent Federal Poverty Guidelines

If your family income is below 200% of the Federal Poverty Income Guidelines, you may qualify for charity care (the hospital will write off 100% of your charges).

If your family income is between 201% and 350% of the Federal Poverty Income Guideline, you may qualify for the discount payment option, leaving a nominal balance as your responsibility.

Sonoma Valley Hospital
Federal Poverty Income Guideline Grid

Size of Family	If income is below 200% of FPG	Above 201% under 350%	Above 351% under 450%
1	$22,340.00	$39,095.00	$50,265.00
2	$30,260.00	$52,955.00	$68,085.00
3	$38,180.00	$66,815.00	$85,905.00
4	$46,100.00	$80,675.00	$103,725.00
5	$54,020.00	$94,535.00	$121,545.00
6	$61.940.00	$108,395.00	$139,365.00
7	$69,860.00	$122,255.00	$157,185.00
8	$77,780.00	$136,115.00	$175,005.00
Patient Liability:			
Write off 100% of balance		75% Discount	50% Discount

If your family income is below 350% of the Federal Poverty Income Guideline and you have high medical
costs (annual medical costs 10% of your family income),
you may qualify for either charity care or discount payment option.

The business office will begin the eligibility determination process once they receive a completed application form along with your family income verification documents and Medi-Cal/CMSP denial/approval letter. Failure to submit a completed application and supporting family income documentation may result in a denial.

How do I apply for financial assistance?
You will need to first apply for county medical assistance with Medi-Cal/CMSP. When denied/approved please provide letter from the county explaining why. Also provide family income documentation, such as most recent tax returns. If you do not file taxes please attach a letter explaining how you support you and your family. Complete the "Financial Assistance Application" form and return all items listed above to the Hospital at:

Sonoma Valley Hospital
Attn: Financial Counselor
347 Andrieux Street Sonoma, Ca. 94954
Fax: 707-935-5319

How will I be notified of my application determination?
Once the eligibility review of your application is complete, you will receive a phone call from our patient accounting office informing you of your new balance.

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

Financial Assistance Application

Patient Name: _____ SSN: _____
Spouse: _____ SSN: _____
Address: _____
City/State/Zip: _____
Account#(s) _____ Phone#: _____

Family Size: _____(include self, spouse and all dependents).
List all dependents that you support on taxes

Name	Age	Relationship
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

If additional space is needed please use the back of page.

Employment (if self employed, give business name)

Employer: _____ Position: _____

Spouse Employer: _____ Position: _____

Current Monthly Income
Must supply proof of income (tax return, pays stubs, etc).

1) Gross wages and salary before deductions _____
2) Income from operating business (if self employed) _____
3) Other income _____
4) Interest and dividends _____
5) Social Security income _____
6) Other _____

Total Current Monthly income _____

By signing this form, I agree to the allow Sonoma Valley Hospital to check employment and credit history for the purpose of determining my eligibility for financial assistance. I understand I may be requested to provide proof of the information I am providing.

_____ _____ _____ _____

Signature of Patient or Guarantor Date Signature of Spouse Date

Sonoma Valley Hospital
Eligibility Determination Worksheet
Office use only

Patient Account Number _____
Date Application Received _____
The patient's gross family income is at or below 200% of the current federal poverty level:
Y____ N____
The patient's gross family income is over 201% and below 350% of the current federal poverty level:
Y____ N____
The patient's gross family income is over 351% and below 450% of the federal poverty level:
Y____ N____

Decision: **( )** 100% write-off Charity Care
( ) 75% Charity Care Discount
( ) 50% Charity Care Discount

Balance on Bill: _____

Charity Care Discount: _____

Patients responsibility $_____

The applicant's request for Financial Assistance has been denied for the following reasons:

( ) The application is incomplete ( ) Not enough supporting documentation received

( ) Income cannot be verified ( ) Over the income and poverty level

Other: _____
_____

Approval:

Revenue Cycle Analyst
or Financial Counselor: _____ up to $5000,

Patient Accounting Manager
or Director of Finance: _____ $5,001-$20,000

CFO: _____ $20,001-above