SIERRA VIEW DISTRICT HOSPITAL
DISCOUNT ELIGIBILITY QUESTIONNAIRE

Completion of the following questions is necessary to evaluate the patient eligibility

DATE __________________

PATIENTS NAME; ____

SOCIAL SECURITY NUMBER_____________________________________

ACCOUNT NUMBER_______________________DATE OF SERVICE_______

HEALTH COVERAGE? _______________SPOUSE LIVING IN HOME? ______

NUMBER OF DEPENDENTS LIVING IN HOME_________________________
(A qualified dependent is someone that can be claimed on your tax return)

GROSS MONTHLY INCOME ___________________________________
(Verification of income {pay stubs, unemployment stubs} must be attached to this questionnaire)

SIGNATURE OF APPLICANT__________________________DATE____

If other than patient, relationship to patient_______________________

Witness Signature____________________________Date_____________

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Insurance Coverage Benefits_____________________________________

Person spoken to:____________________Phone Number _____________

Estimate Charges:____________________% of discount to be given____

Approved______________________Date______________________

Denied________________________Date______________________