Financial Assistance Program for Low Income, Under-Insured or Uninsured Patients
Free Care or Discounted Care Frequently Asked Questions

How do I determine whether I qualify for financial assistance for my hospital bills?
Sonoma Valley Hospital offers Financial Assistance, Free Care, or Discounted Care to All patients. You can see if you qualify for Financial Assistance by using the most recent Federal Poverty Guidelines. California residency is a requirement for financial assistance, Patient Financial Services will not solicit proof of citizenship or Legal Residency as demonstration of California residency.

If your family income is below 300% of the Federal Poverty Income Guidelines, you may qualify for Financial Assistance (the hospital will write off 100% of your balance). If your family income is between 301% and 400% of the Federal Poverty Income Guideline, you may qualify for the discount payment option, leaving a nominal balance as your responsibility. If your family has high medical costs (annual medical costs 10% of your family income), you may qualify for either Financial Assistance or discount payment option.

How do I apply for financial assistance if I am insured but low income?
The business office will begin the eligibility determination process once they receive a completed application form along with your family income verification documents. Failure to submit a completed application and supporting family income documentation may result in a denial.

How do I apply for financial assistance if I am uninsured (self-pay)?
You will need to first be screened for Hospital Presumptive Eligibility by our Financial Counselor for Medi-Cal. When determination is completed, a letter will be provided to you for signatures. You will need to provide family income documentation, such as the 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 verifications.

Acceptable proof of income includes: ALL Tax Forms Required

- Copy of most recent (2 months) pay stubs for both applicant & co-applicant
- Copy of current year W-2 or 1099 earnings statements for both applicant & co-applicant
- Copy of signed current year's income Tax Returns (for both applicants)
- Copy of current Social Security Allotment letter and/or proof of income

Please return the completed application and supporting documentation to Sonoma Valley Hospital,
Attn: Lisa Stone Patient Accounting, 347 Andrieux Street Sonoma, Ca. 95476
F. 707-935-5319 P. 707-935-5325

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#: _____
MRN # _____ Guarantor # _____

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

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

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

Employment (if self employed, give business name)

Employer: _____ Position: _____

Spouse Employer: _____ Position: _____

Current Monthly Income
Must supply proof of income (tax return, pay 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 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