St. Joseph Health
Santa Rosa Memorial • Petaluma Valley

St. Joseph Health
Santa Rosa Memorial and Petaluma Valley Hospitals
Financial Assistance Application

INSTRUCTIONS

1. Please complete all areas on the attached application. If any area does not apply to you, write "N/A" in the space provided. Attach an additional page if you need more space to answer any question.

2. You must provide most recent proof of income when you submit the application. ***For California, documentation of income shall be limited to recent pay stubs or income tax returns.*** The following documents are accepted as proof of income:

   If you filed a federal income tax return:

   Federal income tax return (Form 1040) from the most recent year, including all schedules and attachments as submitted to the Internal Revenue Service.

   Note: If you were declared as a dependent, please bring the tax return that cites you as a dependent.

   If you did not file a federal income tax return:

   a. Two (2) most recent paycheck stubs showing earnings to date;
   b. If self-employed, provide documentation of earnings from the past three (3) months;
   c. Two (2) most recent check stubs or proof of direct deposit from any Social Security, child support, unemployment, disability, alimony or other payments;
   d. If you are paid only in cash, please have your employer provide a signed and dated written statement explaining the amount and frequency with which you are paid.

   Note: If you have no income, please provide a letter explaining how you support yourself and/or your family.

3. Your application will not be processed until *all* required information is provided.

4. It is important that you complete, sign and submit the financial assistance application along with all required documentation within fourteen (14) days.

5. You *must* sign and date the application. If the patient/guarantor and spouse/domestic partner provide information, both *must* sign the application.

6. If you have questions or require assistance in completing this application, please call your account representative at **(707) 525-5228.**

7. Send your completed application to:

   Santa Rosa Memorial Hospital
   Attn: Financial Assistance
   P.O. Box 4119
   Santa Rosa, CA 95402

The qualification for or against financial assistance will not affect the patient's right to access medically necessary or emergency care.

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Personal Information		
Account Number		
Patient / Guarantor Name		
Has the patient previously received and/or applied for SJH financial assistance?	____Yes ____No	*A prior financial assistance application or decision does not affect the decision on the current application.*
Has the patient applied for other assistance? (Medicaid, Medicare, prescription drug assistance programs, DHS, SSI or other federal programs.)	____Yes ____No	*<u>If Yes,</u> please attach a copy of the signed application for those programs which may be used to qualify for financial assistance.*
Spouse/Domestic Partner Name		
Address (Street)		
Address (City, State, Zip)		
Home Phone	( )	
Work Phone	( )	
Cellular Phone	( )	
Patient/Guarantor SSN		
Spouse/Domestic Partner SSN		

Family Status
List all dependents that you support. (Additional space available on page 5)

Name	Date of Birth	Relationship to Patient

Employment Status

	Patient / Guarantor	Spouse/Domestic Partner
Employer Name		
Position		
Contact Person		
Contact Phone	( )	( )

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Annual Income			
Description	Patient/ Guarantor	Spouse/Domestic Partner	Total
1. Gross Wages & Salary			
2. Self-Employment Income			
3. Interest / Dividends (*Retirement and Deferred Compensation Excluded*)			
4. Rentals / Leases			
5. Social Security			
6. Alimony			
7. Child Support			
8. Unemployment/Disability			
9. Public Assistance			
10. All Other Sources (*Attach list*)			
Total Annual Income			

Assets				
Description	Patient/ Guarantor	Spouse/Domestic Partner	Total Value	Amount Owed (If applicable)
1. Checking Account(s) Balance				
2. Savings Account(s) Balance				
3. Stocks, Bonds, CDs Value				
4. Primary Residence				
5. Other Real Estate *(Attach list)*				
6. Motor Vehicles *(Attach list)*				
7. Other Personal Property				
8. Other_____				
9. Other_____				
10. Other_____				
Total Assets				

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Essential Living Expenses - Please provide information on essential living expenses. (Additional space available on page 5.)	
Description	Amount Paid Per Month
Rent or House Payment and Maintenance	
Food and Household Supplies	
Utilities and Telephone	
Clothing	
Medical and Dental payments	
Insurance	
School or Child Care	
Child or Spousal Support	
Transportation and Auto Expenses, including Insurance, Gas, and Repairs, Installment Payments	
Laundry and Cleaning	
Other Extraordinary Expenses_____	
Other Extraordinary Expenses_____	
Other Extraordinary Expenses_____	

The undersigned declares that all information provided is true and correct to the best of his/her knowledge. The undersigned authorizes St. Joseph Health to verify any information listed in this application. The undersigned expressly grants permission to contact his/her employer, banking and lending institutions, and to check his/her credit history.

Signature of Patient/Guarantor

Signature of Spouse/Domestic Partner

Date

Date

St. Joseph Health Mission Statement: *"To extend the Catholic health care ministry of the sisters of St. Joseph of Orange, by continually improving the health and quality of life of people in the communities we serve."* The St. Joseph Health Financial Assistance Program ensures that all patients seeking our care are treated in the spirit of our core values, regardless of the patient's financial status.

Dignity • Service • Excellence • Justice

We understand that the need for financial assistance can be a sensitive and deeply personal issue. We are committed to maintaining the confidentiality of requests, information, and funding for all who participate in the St. Joseph Health Financial Assistance Program.

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Please use this space to provide any additional information or comments that will help us understand your situation.