

## INSTRUCTIONS FOR COMPLETING APPLICATION FOR CHARITY CARE

IMPORTANT NOTE: These instructions are for obtaining charity care support at Sutter Regional Medical Foundation (SRMF) only. If SRMF grants charity care support, this support does not cover care provided by other medical organizations, including other Sutter Health affiliates, such as Sutter Solano Medical Center, and including providers who work in conjunction with SRMF, such as Bay Imaging (radiology group). The applicant will need to make separate arrangements with each of these other entities. To clarify further, SRMF's support will cover services provided only at these locations:

- Fairfield Medical Offices at 2720 Low Court in Fairfield
- Vacaville Medical Offices at 770 Mason Street in Vacaville
- Rio Vista Medical Office at 690 Main Street in Rio Vista
- Sutter Fairfield Medical Campus at 2702 Low Court in Fairfield
- Vallejo Medical Office at 100 Hospital Dr 2<sup>nd</sup> Floor
- Sutter Delta Medical Group Offices

Qualification for charity care at Sutter Regional Medical Foundation (SRMF) requires the completion of the following tasks:

1. Complete and sign the "Statement of Financial Condition". NOTE: we have received this signed form from you and have a copy on file.
2. Attach copies of the following documentation, if available:
  - a. A copy of your last pay check stub (required)
  - b. A copy of your W-2 from last year's income tax filing (required)
  - c. Copies of documentation from the Social Security Administration regarding Social Security benefits
  - d. Copies of documentation from local welfare agencies documenting your financial situation
  - e. Copies of documentation related to any health care insurance coverage for which you have applied or for which you have been denied --- e.g., Medicare, MediCal, or insurance through your employer.
3. Please note that by completing this application, you are agreeing to allow SRMF to verify your employment, credit, and welfare benefit history.
4. Mail, or hand deliver to any SRMF office, a copy of the Statement of Financial Condition and the supporting documentation addressed to:

Patient Financial Representative  
Sutter Regional Medical Foundation  
2720 Low Court  
Fairfield, CA 94534

5. The Patient Financial Representative will review the statement and the supporting documentation and determine the level of charity support that will be provided. This process may entail obtaining additional information from you, your employer, or another entity. It is our goal to make the determination within five business days of receipt of the application.
6. The Patient Financial Representative will communicate the decision regarding the level of financial support to you via mail service and to others within SRMF via our email and billing systems.
7. Any questions regarding the status of your account with SRMF will be answered by the Customer Service Department of Sutter Connect, which manages SRMF's billing service. You may call Customer Service at 1-866-233-5330 between the hours of 8 a.m. and 5 p.m.
8. If you receive a billing statement from SRMF, please call Customer Service at the number listed above.

## STATEMENT OF FINANCIAL CONDITION

<b>PATIENT NAME</b> _____ <b>ADDRESS</b> _____ <b>ACCOUNT #</b> _____	<b>SPOUSE</b> _____ <b>PHONE</b> _____ <b>SSN</b> _____ <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>(PATIENT)</span> <span>(SPOUSE)</span> </div>
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**FAMILY STATUS: List all dependents that you support**

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	Spouse
<i>Add:</i> Gross Pay (before deductions)	_____	_____
<i>Add:</i> Income from Operating Business (if Self-Employed)	_____	_____
<i>Add:</i> Other Income:		
Interest and Dividends	_____	_____
From Real Estate or Personal Property	_____	_____
Social Security	_____	_____
Other (specify):	_____	_____
Alimony or Support Payments Received	_____	_____
<i>Subtract:</i> Alimony, Support Payments Paid	_____	_____
<i>Equals:</i> Current Monthly Income	_____	_____
Total Current Monthly Income (add Patient+Spouse Income from above)	_____	_____

**FAMILY SIZE**

Total Family Members \_\_\_\_\_  
 (add patient, spouse and dependents from above)

By signing this form, I agree to allow Sutter Health to check employment and credit history for the purpose of determining my eligibility for a financial 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)