

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.

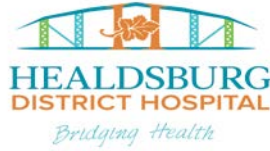
5. You *must* sign and date the application. If the patient/guarantor and spouse/domestic partner provide information, both *must* sign the application.

6. If you have questions or require assistance in completing this application, please call your account representative at (707) 431-6500.

7. Send your completed application to:

Healdsburg District Hospital
Attn: Financial Assistance
1375 University Avenue
Healdsburg, CA 95448

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



Financial Assistance Application

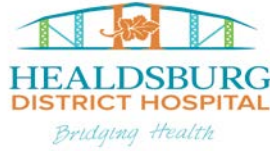
Personal Information		
Account Number		
Patient / Guarantor Name		
Has the patient previously received and/or applied for HDH financial assistance	<input type="checkbox"/> Yes <input type="checkbox"/> No	A prior financial assistance application or decision does not affect the decision on the current application.
Has the patient applied for other assistance? <small>(Medicaid, Medicare, DHS, SSI or other federal programs)</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please attach a copy of the signed application for those programs.
Spouse/Domestic Partner Name		
Address (street)		
Address (City, State, Zip)		
Home Phone		
Work Phone		
Cell Phone		
Patient/Guarantor SSN		
Spouse/Domestic Partner SSN		
Family Status		
List all dependents that you support (Use back if additional space is needed)		
Name	Date of Birth	Relationship to Patient
Employment Status		
	Patient/Guarantor	Spouse/Domestic Partner
Employer Name		
Position		
Contact Person		
Contact Phone		



Financial Assistance Application

Annual Income			
Description	Patient/ Guarantor	Spouse/Domestic Partner	Total
1. Gross Wages and Salary			
2. Self-employment Income			
3. Interest/Dividends			
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
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 _____				
Total Assets				



Financial Assistance Application

Essential Living Expenses	
Description	Amount Paid Per Month
Rent or House Payment	
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 _____	

The undersigned declares that all information provided is true and correct to the best of his/her knowledge. The undersigned authorizes Healdsburg District Hospital 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