



**Financial Assistance Program For Low Income
Uninsured Patients
Frequently Asked Questions**

How do I determine whether I qualify for financial assistance for my hospital bills?

Sonoma Valley Hospital offers Charity Care Discount Payment options to our low-income, uninsured patients that meet the program eligibility requirements. Using the most recent Federal Poverty Guidelines

If your family income is below 200% of the Federal Poverty Income Guidelines, you may qualify for charity care (the hospital will write off 100% of your charges).

If your family income is between 201% and 350% of the Federal Poverty Income Guideline, you may qualify for the discount payment option, leaving a nominal balance as your responsibility.

Sonoma Valley Hospital Federal Poverty Income Guideline Grid			
Size of Family	If income is below 200% of FPG	Above 201% under 350%	Above 351% under 450%
1	\$25,760	\$45,080	\$57,960
2	\$34,480	\$60,970	\$78,390
3	\$43,920	\$76,860	\$98,820
4	\$53,000	\$92,750	\$119,250
5	\$62,080	\$108,640	\$139,680
6	\$71,160	\$124,530	\$160,110
7	\$80,240	\$140,420	\$180,540
8	\$89,320	\$156,310	\$200,970
Patient Liability:			
	Write off 100% of balance	75% Discount	50% Discount

If your family income is below 350% of the Federal Poverty Income Guideline and you have high medical costs (annual medical costs 10% of your family income), you may qualify for either charity care or discount payment option.

The business office will begin the eligibility determination process once they receive a completed application form along with your family income verification documents and Medi-Cal/CMSP denial/approval letter. Failure to submit a completed application and supporting family income documentation may result in a denial.

How do I apply for financial assistance?

You will need to first apply for county medical assistance with Medi-Cal/CMSP. When denied/approved please provide letter from the county explaining why. Also provide family income documentation, such as 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 items listed above to the Hospital at:

**Sonoma Valley Hospital
Attn: Lisa Stone Patient Accounting
347 Andrieux Street Sonoma, Ca. 95476
Fax: 707-935-5319**

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.



Financial Assistance Application

Patient Name: _____ SSN: _____
 Spouse: _____ SSN: _____
 Address: _____
 City/State/Zip: _____
 Account#(s) _____ Phone#: _____

Family Size: _____ (include self, spouse and all dependents).

List all dependents that you support on taxes

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

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

Employment (if self employed, give business name)

Employer: _____ Position: _____

Spouse Employer: _____ Position: _____

Current Monthly Income

Must supply proof of income (tax return, pays 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



Sonoma Valley Hospital
Eligibility Determination Worksheet
Office use only

Patient Account Number _____

Date Application Received _____

The patient's gross family income is at or below 200% of the current federal poverty level:

Y____ N____

The patient's gross family income is over 201% and below 350% of the current federal poverty level:

Y____ N____

The patient's gross family income is over 351% and below 450% of the federal poverty level:

Y____ N____

- Decision:** 100% write-off Charity Care
 75% Charity Care Discount
 50% Charity Care Discount

Balance on Bill: _____

Charity Care Discount: _____

Patients responsibility \$ _____

The applicant's request for Financial Assistance has been denied for the following reasons:

The application is incomplete Not enough supporting documentation received

Income cannot be verified Over the income and poverty level

Other: _____

Approval:

Revenue Cycle Analyst
or Financial Counselor: _____ up to \$5000,

Patient Accounting Manager
or Director of Finance: _____ \$5,001-\$20,000

CFO: _____ \$20,001-above