Exhibit D

STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____ SPOUSE _____
ADDRESS _____ PHONE _____
ACCOUNT# _____ SNN _____ _____
(PATIENT) (SPOUSE)

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
	Gross Pay (before deductions)		
Add:	Income from Operating Business (if Self-Employed)	_____	_____
Add:	Other Income:		
	Interest and Dividends	_____	_____
	From Real Estate or Personal Property	_____	_____
	Social Security	_____	_____
	Other (specify):	_____	_____
	Alimony or Support Payments Received	_____	_____
Subtract:	Alimony, Support Payments Paid	_____	_____
Equals:	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)

	Yes	No
Do you have health insurance?	☒	☒
Do you have other Insurance that may apply (such as an auto policy)?	☒	☒
Were your injuries caused by a third party (such as during a car accident or slip and fall)?	☒	☒

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 financing 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)

Exhibit E

CHARITY CARE CALCULATION WORKSHEET

Patient Name: _____ Patient Account #: _____
Affiliate: _____

Special Considerations/Circumstances: _____
_____
_____
_____

	Yes	No
Does Patient have Health Insurance?	☒	☒
Is Patient Eligible for Medicare?	☒	☒
Is Patient Eligible for Medi-Cal?	☒	☒
Is Patient Eligible for Other Government Programs (i.e. Crime Victims, etc.)?	☒	☒

If eligibility exists for above programs, patient will not generally be eligible for charity care.

Does Patient have other insurance (i.e. auto medpay)?	☒	☒
Was Patient inured by a third party?	☒	☒
Is Patient Self-Pay??	☒	☒

Charity/Financial Assistance Calculation:

Total Combined Current Monthly Income (From Statement of Financial Condition) $_____

Family Size (From Statement of Financial Condition) _____

Qualification for Charity Care/Financial Assistance (circle one): Full Partial

(Identify using eligibility guide) Catastrophic No Eligibility

Partial Charity Write-off Calculation (complete this section only if patient qualifies for partial charity care):

A. Total Charges $_____

B. Medicare 120% Net Cost/Charge Ratio for Facility _____

C. Patient Liability (Line A *times* Line B) $_____

D. Discount Amount (Line A *minus* line C) $_____

Exhibit E

Catastrophic Charity Write-off Calculation (complete section only if patient qualifies for catastrophic charity w/o*):*

A. Patient Liability (total charges unless another discount has been applied)	$_____
B. Annual Income	$_____
C. Patient Liability as Percent of Annual Income	_____%
D. Is line A divided by Line B greater than .30 (30%)?	Yes No
E. If no, patient is not eligible for this type of write-off	_____$0_____
F. If Yes, multiply Line B by 30% to identity the patient liability amount.	$_____
G. If Yes, Subtract line F from Line A to identify the write-off amount.	$ _____
Total Amount of Recommended Charity Write-off(s)	**$_____**

Worksheet Completed by: _____ Phone:_____

Approved by: _____