Sierra Vista Hospital Charity Application

Have you applied for Charity Care before today? ___Yes ___No If Yes, when did you apply_____
(Have your circumstances or information changed (address, phone, employment, spouse employment, rent, own, etc.)

Patient Name _____ Date of Birth _____ SSN#_____

Address_____ City_____ State_____ Zip_____

Spouse's Name _____ Number of **Dependent** Children _____ Children's Ages: _____

Your Employer_____ How long with Employer: _____

Previous Employer (If less than 2 yrs with present employer) _____

How often are you paid_____ Gross Salary (per pay period) _____

Spouse's Employer _____ How long with Employer_____

Spouse's Previous Employer (If less than 2 yrs with present employer) _____ ___

How often is spouse paid_____ Gross Salary (per pay period) _____

Date you became a resident of Sierra County _____ DO YOU: **Rent** ___
Own – Home ___ Mobile Home ___

You must provide proof of income or verification of financial assistance.

We need copies of **TWO (2)** of the following items:

- ☐ Photo ID (Copy)
- ☐ Current Tax Return
- ☐ Social Security Check
- ☐ Bank Statement showing Direct Deposit
- ☐ Pay Stubs/Check Stubs (Minimum of 2 Pay Stubs)
- ☐ Affidavit (notarized statement) from person(s) who provide for you financially

I certify that the information stated on this application is complete and accurate.

_____ _____
Applicant Signature Date

Hospital Use Only:

Gross Annual Pay: _____ Total Number in Family: _____ Charity % Approved: _____

_____ _____
Manager's Signature Date