

Asset Valuation Worksheet

Guarantor Name: _____

Spouse's Name: _____

1. List all current liquid assets:

Savings account balance	\$ _____
Checking account balance	\$ _____
Mutual funds (current market value)	\$ _____
Stocks/bonds (current market value)	\$ _____
Other: _____	\$ _____
TOTAL	\$ _____ (D)

2. Amount of monthly payment you are requesting to pay Sutter North

\$

3. Please provide the following:

- Copies of pay stubs or proof of income for the last twelve months or last year's W2 forms
- Bank statements for the past two months
- Proof of other income sources (pension, disability, AFDC, social security, unemployment, other support, investments)
- Proof of no medical insurance coverage (Example: letter from insurance giving termination date)
- Denial letter from Medi-Cal

3. Please mail your completed application to: Sutter North Medical Foundation
P.O. Box 2690, Marysville, CA 95901-2690

The information provided above has been completed to the best of my knowledge. I/we authorize Sutter North Medical Foundation or its agents to obtain a credit profile for the use of evaluating our request for payment. I understand that the information being submitted is subject to verification by Sutter North Medical Foundation and subject to review by governmental agencies.

Guarantor's Signature _____ Date _____

Spouse's Signature _____ Date: _____

TO BE COMPLETED BY SUTTER NORTH MEDICAL FOUNDATION PERSONNEL ONLY

Date Application Received _____ by _____ (name, title)

STATEMENT OF FINANCIAL CONDITION

PATIENT NAME _____ ADDRESS _____ ACCOUNT # _____	SPOUSE _____ PHONE _____ SSN _____ <div style="display: flex; justify-content: space-around; font-size: small;"> (PATIENT) (SPOUSE) </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)
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(Signature of Spouse)	(Date)
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