*To Our Valued Patient:*

*Thank you for choosing Savoy Medical Center (SMC) for your healthcare needs. Enclosed you will find an application for hospital financial assistance. This is for your hospital charges only. Please return the completed application and provide all supporting documentation to the hospital business office.*

*Patients with a family income at or below 400% of the applicable federal poverty guideline who lack sufficient funds to pay their bills may be eligible for assistance. Patients with significant medical bills regardless of income may also be eligible for assistance. In addition to partial or full adjustments, assistance includes extended payment arrangements.*

*We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential. It will only be shared within SMC on a need to know basis.*

*Upon receipt of a completed application, our staff will conduct a review of the application for possible assistance towards the balance on your account(s) with SMC. We will notify you in writing after our review.*

*Again, we would like to thank you for choosing SMC for your health care needs. If you have any questions regarding the application or the above information, please contact a hospital financial counselor or call the number listed below.*

*Sincerely,*

*SMC*

*337-468-0147*

*Monday – Friday*

*8:00 AM to 5:00 PM (central)*

SAVOY MEDICAL CENTER

Attn: Financial Assistance 801 POINCIANA AVE

MAMOU, LA 70554

Application Date: Guarantor Name (if not patient):

Patient Name: Date(s) of Service:

Hospital Account # Medical Record #

***FINANCIAL ASSISTANCE APPLICATION***

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| *Patient(s) Name: Account #:*  ***YOU MUST PROVIDE AT LEAST 1 OF THE FOLLOWING: YOU MUST PROVIDE PROOF OF IDENTITY WITH***  *Most recent and complete Income Tax Return* ***AT LEAST 1 THE FOLLOWING:***  *3 most recent pay check stubs Current Driver’s License Alien Registration*  *3 most recent checking/savings account statements Passport State-Issued Identification Card*  *Food Stamp or SSI/SSA/SSD award letter*  *If you report a $0 income, please attach a brief explanation of how you or the patient are meeting basic needs* |
| ***PERSONAL DATA: RESPONSIBLE PERSON SPOUSE***  *Name Social Security # Date of Birth Street Address/Apt. # City, State, Zip Home Phone #* |
| ***EMPLOYMENT DATA:***  *Employer Name Explain, if self-employed Address Phone #*  *# of Hours Worked/Week Job Title Length of Employment Yrs Months Yrs Months Gross Monthly Salary* |
| ***OTHER HOUSEHOLD MEMBERS:***  *Name Age \_ DOB Relationship Name Age \_ DOB Relationship Name Age \_ DOB Relationship Gross Monthly Salary* |
| ***ADDITIONAL INCOME: DEBT: OTHER EXPENSES:***  *2nd Job: N Y: $ /month Home Mortgage: $ /month Medical Bills: $ /month Small Business: N Y: $ /month Held by: Pharmacy Bills: $ /month Other: (ex. investments, savings, child support, Unpaid Balance: $ Other: (ex. loans, rent, cable, gas other governmental aid) $ /month Automobile/Boat/RV etc: $ /month phone, utilities, food) $ /month*  *Are any third parties potentially liable for your medical expenses (i.e. auto insurance, workers’ compensation, lawsuit)? Yes No*  *I certify that I am unable to pay for all the costs of necessary services and that the information I have given to SMC Health is true and accurate. I understand that SMC Health will use this information to determine my eligibility for financial assistance. I have disclosed all my assets and income. Failure to report assets or income could result in legal recourse, including criminal charges. I agree to report any changes in my financial status to SMC Health. I authorize SMC, or any credit reporting agency, to investigate any reference, statements, employment, or other data given by me or any other person pertaining to my credit and financial responsibility.*  *Patient/Guarantor Signature Date Spouse’s Signature Date* |