



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 300% 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,
Debbie Caudle
SMC*

*Phone:337-468-
0147*

Monday – Thursday

7:30 AM to 4:30 PM (central)

Friday

8:00 AM to 2:30 PM (central)



SAVOY MEDICAL CENTER
Attn: Financial Assistance
801 POINCIANA AVE
MAMOU, LA 70554

APPLICATION NEW _____ RENEWAL _____

Application Date: _____ Guarantor Name (if not patient): _____

Patient Name: _____ Date(s) of Service: _____

Hospital Account # _____ Total balance _____



FINANCIAL ASSISTANCE APPLICATION

Patient(s) Name: _____ Account #: _____

YOU MUST PROVIDE AT LEAST 1 OF THE FOLLOWING:

- ___ Most recent and complete Income Tax Return
- ___ Food Stamp or SSI/SSA/SSD award letter

YOU MUST PROVIDE PROOF OF IDENTITY WITH AT LEAST 1 THE FOLLOWING:

- ___ Current Driver's License ___ Alien Registration
- ___ -Passport ___ State-Issued Identification Card

PERSONAL DATA:

RESPONSIBLE PERSON

SPOUSE

Name	_____	_____
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:

2nd Job: N Y: \$_____/month
Small Business: N Y: \$_____/month
Other: (ex. investments, savings, child support, governmental aid) \$_____/month

DEBT:

Home Mortgage: \$_____/month
Held by: _____
Unpaid Balance: \$_____
Automobile/Boat/RV etc: \$____/month

OTHER EXPENSES:

Medical Bills: \$_____/month
Pharmacy Bills: \$_____/month
Other: (ex. loans, rent, cable/Internet, gas, phone, utilities, food/hygiene Auto ins.) \$_____ 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 _____