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
Monday – Thursday
7:30 AM to 4:30 PM (central)
Friday
8:00 AM to 2:30 PM (central)

Phone: 337-468-0147

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)? YesNo

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* __________________________