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 150% 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 _____

SAVOY MEDICAL CENTER

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 _____

SAVOY MEDICAL CENTER

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, governmental aid) $_____/month	*Unpaid Balance: $_____* *Automobile/Boat/RV etc: $___/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* _____