SPRINGHILL MEDICAL SERVICES, INC.

2001 Doctors Drive
PO Box 920
Springhill, LA 71075
(318) 539-1000

FINANCIAL ASSISTANCE APPLICATION

(ALL INFORMATION WILL BE CONFIDENTIAL)

The following instructions are provided to assist you in completion of the attached financial assistance application. **All sections of the application must be completed, signed, and returned within Fourteen (14) days for it to be considered.**

Section 1: **Personal Information:**

Please complete all sections that apply to your situation

Section 2: **Income:**

You will be required to submit copies of proof of income. Your application cannot be processed without proof of income.

Please submit the following:

a) Last years signed income tax form as submitted to the IRS

b) Copy of your last 3 most current pay stubs indicating gross or per hour pay rate

c) If the above proof of income is not available you may submit a letter from your employer on company letterhead indicating your yearly salary or hourly rate of pay, benefit letter from worker's compensation, copy of your social security check (if social security check is direct deposited a copy of bank statement showing deposit), or your retirement pensions

Section 3: **Expenses**

You will need to provide a copy of your most current gas, water, and electric bills.
If you are receiving Food Stamps we will need a copy of your award letter.

Section 4: **Household Members**

List everyone that you claim on your tax return.

Please complete all sections **applicable to your situation** and be sure that **all required signatures have been made.** If you qualify you will be responsible for paying your percentage of the charge on the date of your visit. If you do not qualify you will be responsible for the total charge the day of your visit. Should you have any questions, please contact our office at (318) 539-1095 or (318) 539-1701.

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PO BOX 920
SPRINGHILL, LA 71075
(318) 539-1701

REQUEST FOR FINANCIAL ASSISTANCE

Section 1:

Patient Name: _____ Date of Birth: _____

Address: _____ Phone (Cell): _____

_____ Phone (Home) _____

Date of Application: _____

Section 2:

Please provide the documents needed to verify your income:
1) Income tax return for last year
2) Pay stub(s) from employer(s) (3 most current)
3) Letter from employer if terminated
4) Copies of all medical bills owed

Failure to return this information and form within *14 days* may result in denial of your Financial Assistance Application.

Please list all monthly family income:
Wages: Patient _____
Spouse _____
Dependents _____
Public Assistance: _____
Social Security: _____
Workmen's Comp: _____
Alimony: _____
Child Support: _____
Pensions: _____
Unemployment: _____
VA Benefits: _____
Savings _____
Other Income: _____
COMBINED TOTAL MONTHLY INCOME:
$ _____

Section 3:

Please list all monthly expenses:
House/Rent Payment per Month: _____
Food Allowance Per Month: _____
Utilities: _____
Transportation Expense: _____
Medical Expense Payment: _____

Insurance Premiums: _____
Auto Payments: _____
Credit Card Payment: _____
Other Monthly Payment: _____

TOTAL MONTHLY EXPENSE: $_____

Section 4: Household Members

Name of Member	Relationship to patient	Date of Birth	Age

I do attest that the above information is a true and accurate account of my financial situation, and understand that in accordance with s. 817.50 providing false information to defraud a hospital for purposes of obtaining services is a misdemeanor in the second degree.

_____ _____
Responsible Party Signature **Date**

_____ _____
Account Representative Signature **Date**