NOVA SCOTIA

Department of Health and Wellness

To:

Contact Name , DOH Finance

Insert FSO Address Information Above

From:

FSO Name and District

Reset Print

Date:

Re: Self Managed Care Client _____

Client's Name

Please SMC monthly payments to _____ to _____
per month effective *Client's Name*

Date - usually start of month

Please advise if you need anything further in order to these payments.

Thanks,

FSO Name