

Financial Assistance

Southwest General Health Center offers a variety of programs to assist you with your medical bills. If you were a resident of the state of Ohio and your situation meets the family and financial eligibility requirements below, your bill for emergency medical or medically necessary care maybe discounted under the Southwest General Financial Assistance Policy.

2023 FEDERAL POVERTY LIMITS			
Family Size	100% Federal Poverty Guidelines	101 - 250% Federal Poverty Guidelines	251 – 400% Federal Poverty Guidelines
1	\$14,580	\$36,450	\$58,320
2	\$19,720	\$49,300	\$78,880
3	\$24,860	\$62,150	\$99,440
4	\$30,000	\$75,000	\$120,000
5	\$35,140	\$87,850	\$140,560
Additional Family Members	\$5,140	\$12,850	\$20,560
	100% Discount	100% Discount	AGB Rates

The definition of “family” shall include:

Patient is over the age of 18: their spouse, and all their children, natural or adoptive, under the age of eighteen who live in the home.

If the patient is under the age of eighteen the “family” shall include the patient, the patient’s natural or adopted parent(s) (regardless if they live in the home), and the patient(s) children, natural or adopted under the age of eighteen who live in the home.

If it appears that you may be eligible for assistance from Federal or State agencies, you are required to apply to these agencies before your request for financial assistance is finalized.

Contact us:

If you think you may be eligible for financial assistance, please complete the application form and send it with income verification to:

Parallon
 P.O. Box 291569
 Nashville, TN 37229-1569

Should you have any questions, please contact customer service at:

(844) 902-3811 Monday-Friday 8:00a.m. – 7:00p.m.

OR

Financial Clearance at:

(440) 816-4701 Monday-Friday 8:00 a.m – 4:30p.m.



Financial Assistance Application



If you believe you may qualify for financial assistance, complete this application. The entire application, including signature must be completed and signed to be considered

Patient's Name: _____ Date of Birth: _____ Marital Status: _____
 Address: _____ Phone: _____ Acct#: _____
 City: _____ State: _____ Zip Code: _____
 Dates of Service: _____

- ✓ Were you an Ohio resident on this date of service? Yes No
- ✓ Do you have health insurance covering these services? Yes No
 If yes, enter information below and attach copy of insurance card
 Name of Insurance Co.: _____
 Policy #: _____
 Group #: _____
- ✓ Are you eligible for COBRA Yes No
- ✓ Do you have Medicaid benefits? Yes No
 If Yes, enter billing number: _____
 Attach copy of Medicaid card.
- ✓ Do you have a:
 - Health Reimbursement Arrangement Health Savings Account
 - Flexible Spending Account

Please list all household members below. Include parents, spouses (regardless if they live in the home) & children (natural or adoptive) under the age of 18 living in the home along with the patient. Include copies of income verifications such as pay stubs, social security determinations, workers compensation, tax returns, or call the Southwest billing department at (844) 530-1996 or (440) 816-4701 to discuss other evidence that may be provided to demonstrate eligibility.

Patient Family Members	Age	Relationship to Patient	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service
(Patient)		Self			

If you reported \$0.00 income above, please provide a brief explanation of how you (or the patient) survived financially during the period requested above: _____

By my signature below, I attest to the best of my knowledge and belief that the answers on this application are true. I understand that it is unlawful to knowingly submit false information to obtain government benefits. I further understand that other parties may rely on this information I provide herein. I hereby authorize them to do so.

Responsible Party Signature _____ Date _____