

**IMPORTANT INFORMATION
TO ALL NEIGHBORHOOD CARE CENTER PATIENTS AND
APPLICANTS**

Enrollment in the Southwest General Neighborhood Care Center and renewals will be done by mail. To help us assist you please complete the attached form and include copies of the following:

- Please provide proof of citizenship: a copy of passport, green card, or birth certificate.

- Please provide proof of income from the most recent 3 pay periods.

- Please provide written documentation from your employer that health insurance is not provided to employees at your place of employment.
You will not be accepted into the program if you are currently insured, you or your spouse's employer offers health insurance but you choose not to purchase coverage, or if you are visiting the area temporarily.

- Please provide proof of residency for our taxing district (Berea, Brook Park, Columbia Township, Middleburg Heights, Olmsted Falls, and Strongsville) in the form of recent utility bill.

- If you have reported very little or no income, please provide a letter of survival off of low income. This is a description in your words of how you are living on the income you bring in, and covering basic needs.

Please send all requested information to:

**Attn: Patient Accounts Department
Southwest General Health Center
18697 Bagley Rd.
Middleburg Hts., OH 44130**

Please call The Neighborhood Care Center at 440-816-6444 for any questions.

Neighborhood Care Center



18697 Bagley Road
Middleburg Heights, OH 44130-3497

Financial Assistance

Southwest General Health Center is required to provide emergent medically necessary healthcare without charge to persons who cannot afford to pay for care.

You are eligible for medically necessary healthcare at no cost to you if you are on Disability Assistance (DA) or if your family income does not exceed the Federal Poverty Income Guidelines. See schedule below.

You may be eligible for medically necessary healthcare at reduced cost to you if your family income does not exceed 400% of the Federal Poverty Income Guidelines. See schedule below:

Family Size	100% Federal Poverty Guidelines	101 - 250% Federal Poverty Guidelines	251 – 400% Federal Poverty Guidelines
1	\$11,170	\$27,925	\$44,680
2	\$15,130	\$37,825	\$60,520
3	\$19,090	\$47,725	\$76,360
4	\$23,050	\$57,625	\$92,200
5	\$27,070	\$67,525	\$108,040
6	\$30,970	\$77,425	\$123,880
7	\$34,930	\$87,325	\$139,720
8	\$38,890	\$97,225	\$155,560
9	\$42,850	\$107,125	\$171,400
10	\$46,810	\$117,025	\$187,240
Additional Family Members	\$3,960	\$9,900	\$15,840
Then	100% Discount	100% Discount	Medicare Rates

***If the patient has insurance and the co-pay or self insurance is \$1,156.00 or more, the charges will be reduced for those patients with an income of less than 250% of the federal poverty guidelines.**

The definition of “family” shall include the parent(s), their spouse, and all their children, natural or adoptive, under the age of eighteen who live in the home.

If you have health insurance coverage by an insurance plan provided by your employer, yourself or Medicare, you may receive medically necessary services at no cost or a reduced cost if they are not covered by the plan and you qualify for financial assistance. 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.

If you are not on active Disability Assistance, and you think you may be eligible for financial assistance, please complete the application form on the back of this letter and send it to the Patient Accounts Department at the above listed address. The Patient Accounts Department will make a written determination of your eligibility and send a copy to you.

Should you have any questions, please contact the Patient Accounts Department at (440) 816-8644 between the hours of 8:00a.m. and 4:30p.m., Monday through Friday.

Financial Assistance Application

Patient's Name: _____ Date of Application: _____

Applicant's Name, if not Patient: _____
 (If the applicant is not the patient, please answer the following questions as they apply to the patient.)

Street: _____ City: _____

State: _____ Zip Code: _____

Dates of Hospital Service: from _____ to _____

- ✓ Were you an Ohio resident at the time of your hospital service? Yes No
 If no, place of residency _____
- ✓ Were you an active Medicaid recipient at the time of your hospital service? Yes No
 If Yes, Medicaid recipient ID number: _____
- ✓ Were you an active recipient of Disability Assistance at the time of your hospital service? Yes No
 (If you answered Yes to this question, please attach a copy of your DA card effective during your hospital service to this application.)
- ✓ Did you have health insurance (other than Medicaid) at the time of your hospital service? Yes No

Please provide the following information for all the people in your immediate family who live in your home. "Family" is defined as the patient, the patient's spouse, and all of the patient's children under 18 (natural or adoptive) who live in the patient's home.

Name	Age	Relationship to Patient	Gross Income for 3 months prior to hospital service	Gross Income for 12 months prior to hospital service
(Patient)		Self		
Total persons in family		Total family income		

Income verification should accompany this application. It may include pay stubs or other documents containing income information for the **three months prior to the hospital services for which you are requesting assistance**. Gross income is total salaries, wages and all cash receipts **before taxes**. **If you have reported very little or no income, please attach an explanation of how you are obtaining food and shelter.**

By my signature below, I certify that everything I have stated on this application and on any attachments is true.

Applicant Signature _____ Date _____