Southwest General
Partnering with University Hospitals

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.

2019 Federal Poverty Limits

Family Size	100% Federal Poverty Guidelines	101%-250% Federal Poverty Guidelines	251-400% Federal Poverty Guidelines
1	$12,490	$31,225	$49,960
2	$16,910	$42,275	$67,640
3	$21,330	$53,325	$85,320
4	$25,750	$64,375	$103,000
5	$30,170	$75,425	$120,680
Additional Family Members	$4,420	$11,050	$17,680
	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 13620
Richmond, VA 23225-8620

Should you have questions, please contact our customer service at:
(844) - 530-1996 Monday – Friday 8:00a.m to 7:00p.m.
OR
Financial Clearance at: (440) -816-4701 Monday – Friday 8:00a.m. to 4:30p.m.

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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 Name: _____ Date of Birth: _____ Marital Status: _____

Address: _____ Phone Number: _____ Account #:_____

City: _____ State: _____ Zip Code: _____

Date of Service: _____

Were you an Ohio resident on this date of service? O Yes O No

Do you have health insurance covering these services? O Yes O No
If yes, enter information below and attach copy of insurance card
Name of Insurance Company: _____
Policy #_____
Group # _____

Are you eligible for COBRA? O Yes O No

Do you have Medicaid benefits? O Yes O No
If yes, enter billing #_____ & attach copy of Medicaid card

Do you have a O Health Reimbursement Arrangement O Health Savings Account O 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
1.Patient -		Self			
2.					
3.					
4.					
5.					

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: X_____ Date: _____