

## 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.

2026 FEDERAL POVERTY LIMITS			
Family Size	100% Federal Poverty Guidelines	101 - 250% Federal Poverty Guidelines	251 – 400% Federal Poverty Guidelines
1	\$15,960	\$39,900	\$63,840
2	\$21,640	\$54,100	\$85,560
3	\$27,320	\$68,300	\$109,280
4	\$33,000	\$82,500	\$132,000
5	\$38,680	\$96,700	\$154,720
6	\$44,360	\$110,900	\$177,440
7	\$50,040	\$125,100	\$200,160
8	\$55,720	\$139,300	\$222,880
<b>For each Additional Family Member over 8 add \$5,680 per month.</b>			
	<b>100% Discount</b>	<b>100% Discount</b>	<b>AGB Rates</b>

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.

- SWGH will provide Free Care to individuals whose family size and household income is less than or equal to 100% of the current Federal Poverty Guidelines.
- SWGH will provide Free Care to individuals whose family size and household income is less than or equal to 250% of the current Federal Poverty Guidelines.
- SWGH will provide Discounted Care to individuals with a family size and a household income between 251%-400% of the current Federal Poverty Guidelines.
  - “Discounted Care” shall mean care that has been discounted to the rate set forth as the “Amount Generally Billed (“AGB”).
- SWGH offers payment plans.
- Patients who do not qualify for Free Care or Discounted Care may still qualify for financial assistance if they can demonstrate that their medical expenses exceed an established percentage of their family income.

**To apply**, please complete the application and mail it:

Financial Counselor  
Southwest General Medical Center  
18697 Bagley Road  
Middleburg Heights, OH 44130

**To apply online**, visit and click on the link: <https://swgeneral.com/faa>

**For additional questions, please contact** Financial Counseling at:

(440) 816-8249 Monday-Friday 8:00a.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 Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date(s) of Service: \_\_\_\_\_ Acct#(s): \_\_\_\_\_

- ✓ Were you an Ohio resident on this date of service?  Yes  No  
If yes, attach copy of legal ID or other document for verification
- ✓ 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 ID number: \_\_\_\_\_  
Attach copy of Medicaid card.
- ✓ Do you have a:
  - Health Reimbursement Arrangement
  - Health Savings Account
  - Flexible Spending Account
  - Other Financial Resources

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, and tax returns. Call Customer Service at (440) 816-8249 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 \_\_\_\_\_

Date \_\_\_\_\_