Southwest General
Partnering with University Hospitals

18697 Bagley Road
Middleburg Heights, OH 44130-3497

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.

	2025 FEDERAL POVERTY LIMITS		
Family Size	**100% Federal Poverty Guidelines**	**101 - 250% Federal Poverty Guidelines** *(discounts for uninsured patients only)*	**251 – 400% Federal Poverty Guidelines** *(discounts for uninsured patients only)*
1	$15,650	$39,125	$62,600
2	$21,150	$52,875	$84,600
3	$26,650	$66,625	$106,600
4	$32,150	$80,375	$128,600
5	$37,650	$94,125	$150,600
Additional Family Members	$5,500	$13,750	$22,000
	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.

- SWGH will provide Free Care to **insured** individuals whose family size and household income is less than or equal to 100% of the current Federal Poverty Guidelines.
  - **Insured Patients** are individuals who have any governmental or private health insurance.
- SWGH will provide Free Care to uninsured 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 uninsured 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.
- Uninsured 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, along with income and residency verification to:

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

For additional questions, please contact customer service

(844) 530-1996 Monday-Friday 8:00a.m. – 7:00p.m.

Financial Assistance Application

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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 (844) 530-1996 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_____