IMPORTANT INFORMATION

Tift Regional Health System, Inc. offers Financial Assistance programs. For qualified patients, these programs offer full or discounted reductions of covered medical services. The criteria for financial assistance is based on **gross** income, available assets, and family size. In addition to completing the application, other documentation mentioned below is also required to determine eligibility.

*****ORIGINAL OR CERTIFIED COPIES OF DOCUMENTS ARE NOT REQUIRED AND WILL NOT BE RETURNED*****

Proof of income received from **all** sources from **all** household family members is required. Various types of documentation are accepted, but not all are required. The types include, but are not limited to:

- Previous year's tax return.
- Previous 3 month's pay stubs *(if you are paid weekly this would be 12 pay stubs; if you are paid bi-weekly this would be 6 pay stubs)*. All checks must be in consecutive order.
- A written statement from your employer, on letterhead when available, if check stubs or tax returns are not available. **The statement should include the pay rate, pay frequency, and number of hours worked per week for the previous 3 months.** The letter must be dated & signed by the employer & include a contact phone number.
- Benefit award letters for Retirement, Pension, Social Security, Workers Compensation, Unemployment, Short Term Disability, or Long Term Disability.
- Current bank statement showing direct deposit, for Social Security or Retirement **only**.
- Written statement from person giving support that includes the name of the person giving the support as well as the relationship to the patient, type of support *(cash, room & board, etc.)*, and length of support. The letter must be dated & signed by the support person & include a contact phone number. A template statement is available upon request & is on our website listed below.

A **Marital Attestation** form is required from all applicants. Supporting documentation is required & is described on the form. A Financial Counselor can provide this form or it can be printed from our website listed below.

Proof of dependents under the age of 21 is required. Various types of documentation are accepted. The types include, but are not limited to:

- Previous year's tax return, when they are listed as a dependent
- Birth certificate
- Documentation of custody *(court custody papers, school records, etc.)*

Those who have total assets valued at **$125,000** or more, excluding their primary residence, can provide documentation showing the amount they still owe for each asset, if applicable.

Patients/Guarantors may apply for financial assistance at any time up to two-hundred forty (240) days after the first post-discharge billing statement is available. **Your application will not be processed until all required information & documentation is received & all forms are signed & dated.** Approved applications are valid for **six (6)** months. Individual accounts must meet guidelines per our policy to be eligible for adjustments. You may request a reconsideration of a discounted reduction or a denial by providing additional or updated information.

Certain services performed by Tift Regional Medical Center, Tift Regional Medical Center-West Campus, Southwell Medical Center and some Southwell Medical clinics will not be covered. To view a complete list of covered and non-covered facilities/locations see Appendix A on our website listed below.

Services covered by your insurance plan but denied may not be eligible for Indigent/Charity Care assistance. Accounts referred for legal action or secondary collections will not be eligible for Indigent/Charity Care assistance. All applicable means of payment, including, but not limited to, health insurance, liability/auto insurance & other programs/organizations must be satisfied prior to applying any Indigent/Charity adjustments.

Please return all documentation to:

Email: pfsfinancialcounselor@tiftregional.com
Fax: 229-353-6908
Mail: Tift Regional Health System, Inc. / Attn: Financial Counseling Unit / PO Box 807 / Tifton, GA 31793
In Person: 907 E 18th Street / Suite 190 / Tifton, GA 31794 (Professional Building)

The Financial Assistance Policy, the application and other documents are available for printing in English & Spanish on our website, https://mysouthwell.com/financial-assistance/

Financial Counselors are available by phone at 229-353-6124, option 2, to answer questions. **Please allow thirty-(30) days** from receipt of your completed application and all required documents for processing. We will email a letter to you once we have made a determination when an email address is provided; otherwise, we will mail the letter to you to the mailing address on file.

REVISED OCTOBER 1, 2024

SOUTHWELL

TIFT REGIONAL HEALTH SYSTEM, INC (TRHS)

Tift Regional Medical Center/ Southwell Medical,
A Campus of Tift Regional Medical Center

Financial Assistance Policy Plain Language Summary

TRHS Facilities ("TRHS") include not for profit charitable corporations that are committed to providing financial assistance and community services to improve access to care. TRHS is committed to providing health services to patients regardless of their ability to pay. TRHS recognizes that not all patients have the financial resources to pay their hospital bill. This Plain Language Summary provides basic information about our policy.

TRHS Financial Assistance Policy

The Financial Assistance Program offers emergency and other medically necessary services at no cost to qualified patients. Whether patients are uninsured or underinsured, they can apply for financial assistance. Our Financial Counseling staff and a third party service will assist individuals in applying for eligible government health insurance programs and completing the financial assistance application, free of charge. Upon approval, patients may receive the following assistance:

Uninsured (True Self-Pay)	
Federal Poverty Level	Amount of Assistance
<200%	100%
201%-300%	85%
301%-400%	75%
Underinsured (Balance after Insurance)	
<200%	100%
201%-300%	25%
301%-400%	15%

Patients who qualify cannot be charged more than the amount generally billed (AGB).

The Financial Assistance Policy, Application and Plain Language Summary Are Available in Multiple Languages

Financial Assistance Policies, Applications and Plain Language Summaries are available in the following languages:

- English
- Spanish

How to Obtain Copies of our Financial Assistance Program Policy and Application

You may obtain a copy of our policy and application form free of charge in the following ways:

- Our website http://www.mysouthwell.com/
- Visit our Financial Counseling office located at:
  Tift Professional Building
  907 18th Street, Suite 190
  Tifton, GA 31794
- Visit any of the following Tift Regional Medical Center locations:
  - Affinity Clinic-West Campus Registration
    2225 US Highway 41 N.
    Tifton, GA 31794
  - Tift Regional Outpatient Registration or the emergency department
    901 E. 18th Street
    Tifton, GA 31794
- Visit Southwell Medical Registration located at:
  - 260 M.J. Taylor Road
    Adel, GA 31620
- Request copies by calling (229) 353-6124, option 2, or send an email to pfsfinancialcounselor@tiftregional.com

Providers who are not covered under the Financial Assistance Policy

Certain physicians are not covered under the Southwell Financial Assistance policy. Please visit our website or contact us at (229) 353-6124, option 2, for more information.

Return Your Completed Application

Tift Regional Health System, Inc.
Financial Counseling Unit
P.O. Box 807
Tifton, GA 31793

If approved, financial assistance will apply to:

- Tift Regional Medical Center
- Tift Regional Medical Center, West Campus
- Southwell Medical (Adel, GA)
- Other locations can be found at http://www.mysouthwell.com/financial-assistance

Important

Patients/Guarantors may apply for financial assistance at any time up to two hundred forty (240) days after the first post-discharge billing statement is available.

Financial Assistance Application Checklist

Before you turn in your Financial Assistance Application, please make sure you have provided all required information & documentation

	√
1. I have completed all fields in all sections on the application *(Including the income & assets sections--enter zeros or NA if none exists)*	☐
2. I have signed & dated the application	☐
3. I have attached appropriate & complete proof of income *(See information page, 2nd paragraph, for details on what is required)*	☐
4. I have completed the Marital form & provided appropriate documentation *(See information page, 3rd paragraph, or marital form for details on what is required)*	☐
5. I have signed & dated the Marital form & a witness has also signed & dated	☐
6. I have attached proof of dependents under age 21 *(See information page, 4th paragraph, for details on what is required)*	☐

SOUTHWELL

Tift Regional Health System, Inc.
Financial Assistance Application

GUARANTOR: _____
(NO MINORS) LAST FIRST MIDDLE

MAILING ADDRESS: _____

CITY, STATE, ZIP, COUNTY: _____

PHONE #: _____ **EMAIL:** _____

SPOUSE PHONE #: _____ **EMAIL:** _____

(By providing an email address, you are agreeing to receive email communication from Southwell staff regarding this application)

LIST HOUSEHOLD MEMBERS INCLUDING YOURSELF, SPOUSE & DEPENDENTS UNDER 21

NAME	RELATIONSHIP	DATE OF BIRTH	SS#	INSURANCE	
				INSURANCE NAME & POLICY #	EFFECTIVE DATE
	SELF				

LIST ALL HOUSEHOLD MEMBERS WITH INCOME

NAME	RELATIONSHIP	INCOME TYPE	GROSS INCOME AMT PER PAY PERIOD	PAY PERIOD *(weekly, bi-weekly, monthly, etc.)*
	SELF		$	
			$	
			$	
			$	

LIST VALUE FOR HOUSEHOLD ASSETS (ALL PROPERTY, VEHICLES, CHECKING & SAVING ACCOUNTS, IRAs, STOCKS, ETC.)

CHECKING ACCT	SAVINGS ACCT	HOME VALUE	OTHER PROPERTY VALUE
$ _____	**$** _____	**$** _____	**$** _____
VEHICLE #1	VEHICLE #2	VEHICLE #3	IRA
$ _____	**$** _____	**$** _____	**$** _____
STOCKS/BONDS	OTHER	OTHER	OTHER
$ _____	**$** _____	**$** _____	**$** _____

I CERTIFY THAT THE ABOVE INFORMATION PROVIDED IS TRUE AND ACCURATE FOR THE PURPOSE OF EVALUATING MY APPLICATION FOR INDIGENT/CHARITY CARE OR A REDUCED PAYMENT PLAN. I AUTHORIZE TIFT REGIONAL TO CHECK MY CREDIT HISTORY IF NESSECARY. I UNDERSTAND THAT TIFT REGIONAL MAY REVERSE THE DECISION IF ACCURATE INFORMATION IS NOT PROVIDED OR IF IT IS DETERMINED THAT I AM ELIGIBLE FOR COVERAGE UNDER OTHER PROGRAMS OR INSURANCE NOT PREVIOUSLY FILED.

GUARANTOR SIGNATURE: _____ **DATE:** _____
(SIGNATURE REQUIRED)

FOR PFS STAFF ONLY

STATE OF RESIDENCE:
FAMILY SIZE**:** **EFFECTIVE DATE:** **EXPIRATION DATE:**
ANNUAL GROSS INCOME:

APPROVED: 0%-125% INDIGENT *(100%)*
126%-200% CHARITY *(100%)* FINANCIAL COUNSELOR: DATE:
201%-300% CHARITY *(85% / 25%)*
301%-400% CHARITY *(75% / 15%)* FIN COUN SUPERVISOR: DATE:

DENIED: OVER INCOME *(over 400%)* PFS DIRECTOR: DATE:
OVER ASSETS *(over $125,000 net)*

REVISED OCTOBER 1, 2024

SOUTHWELL

Tift Regional Health System, Inc.
Marital Attestation Form

Check the appropriate box below for your current marital status AND provide the appropriate documentation.

Current Marital Status	Date of Occurrence	**Documentation Required**
☐ Married/Remarried	_____	☐Marriage certificate ☐Documentation previously submitted to TRHS
☐ Divorced	_____	☐Final Divorce Decree ☐Documentation previously submitted to TRHS
☐ Separated	_____	☐Court document *(i.e. legal separation, divorce request, etc.)* **OR** ☐Letter on letterhead from a third party to validate separation *(i.e. church official, school official, marriage counselor, etc.)* **OR** ☐Documentation of two physical addresses *(i.e. separate utility bills, rent/mortgage with each person's name, etc.)*
☐ Widowed, *enter spouse name below* _____	_____	☐Death certificate ☐Documentation previously submitted to TRHS ☐Obituary ☐Documentation previously submitted to TRHS
☐ Single, *never married*	N/A	N/A

☐Other (Please explain): _____

_____

_____

By signing this Verification Statement, I (we) certify that all information reported is complete and accurate. <u>WARNING</u>: If you knowingly give false or misleading information on this form, any favorable decision made based on the misinformation may be reversed.

X_____ _____ X_____ _____

(Patient / Responsible Party-*REQUIRED*) Date (Witness-*REQUIRED, not spouse*) Date