



IMPORTANT INFORMATION

Southwell Ambulatory, 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 Southwell Ambulatory, Inc., 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: Nekesha.hill@myouthwell.com

Fax: 229-219-1631

Mail: Southwell Ambulatory, Inc. / Attn: Financial Counseling Unit / 410 Connell Road / Valdosta, GA 31602

In Person: 410 Connell Road / Valdosta, GA 31602

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

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.



SOUTHWELL AMBULATORY, INC (SWA)
Tift Regional Medical Center/ Southwell Medical,
A Campus of Tift Regional Medical Center

Financial Assistance Policy Plain Language Summary

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

SWA 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 <https://mysouthwell.com/southwell-ambulatory/>
- Visit our Financial Counseling office located at:
410 Connell Road
Valdosta, GA 31602

- Request copies by calling (229) 353-6885 or send an email to neksha.hill@mysouthwell.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) 353-6885 for more information.

Return Your Completed Application

Southwell Ambulatory, Inc.
Financial Counseling Unit
410 Connell Road
Valdosta, GA 31602

If approved, financial assistance will apply to:

- Southwell Gastroenterology (Valdosta)
- Southwell Internal Medicine (Valdosta)
- Southwell Lowndes Endoscopy Center (Valdosta)
- Southwell OB/GYN (Valdosta)
- Southwell Valdosta Endoscopy Center (Valdosta)
- Other locations can be found at

<https://mysouthwell.com/southwell-ambulatory/>

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 Ambulatory, 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

Table with 6 columns: NAME, RELATIONSHIP, DATE OF BIRTH, SS#, INSURANCE NAME & POLICY #, EFFECTIVE DATE. Includes a row for SELF.

LIST ALL HOUSEHOLD MEMBERS WITH INCOME

Table with 5 columns: NAME, RELATIONSHIP, INCOME TYPE, GROSS INCOME AMT PER PAY PERIOD, PAY PERIOD (weekly, bi-weekly, monthly, etc.). Includes a row for SELF.

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

Table with 4 columns: CHECKING ACCT, SAVINGS ACCT, HOME VALUE, OTHER PROPERTY VALUE. Includes rows for VEHICLE #1, VEHICLE #2, VEHICLE #3, IRA, STOCKS/BONDS, 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 NECESSARY. 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:

ANNUAL GROSS INCOME:

EFFECTIVE DATE:

EXPIRATION DATE:

APPROVED: 0%-125% INDIGENT (100%)

126%-200% CHARITY (100%)

201%-300% CHARITY (85% / 25%)

301%-400% CHARITY (75% / 15%)

FINANCIAL COUNSELOR: DATE:

FIN COUN SUPERVISOR: DATE:

DENIED: OVER INCOME (over 400%)

OVER ASSETS (over \$125,000 net)

PFS DIRECTOR: DATE:

**Southwell Ambulatory, 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**	
<input type="checkbox"/> Married/Remarried		<input type="checkbox"/> Marriage certificate	<input type="checkbox"/> Documentation previously submitted to TRHS
<input type="checkbox"/> Divorced		<input type="checkbox"/> Final Divorce Decree	<input type="checkbox"/> Documentation previously submitted to TRHS
<input type="checkbox"/> Separated		<input type="checkbox"/> Court document (i.e. legal separation, divorce request, etc.) OR <input type="checkbox"/> Letter on letterhead from a third party to validate separation (i.e. church official, school official, marriage counselor, etc.) OR <input type="checkbox"/> Documentation of two physical addresses (i.e. separate utility bills, rent/mortgage with each person's name, etc.)	
<input type="checkbox"/> Widowed, enter spouse name below		<input type="checkbox"/> Death certificate <input type="checkbox"/> Obituary	<input type="checkbox"/> Documentation previously submitted to TRHS <input type="checkbox"/> Documentation previously submitted to TRHS
<input type="checkbox"/> 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. WARNING: If you knowingly give false or misleading information on this form, any favorable decision made based on the misinformation may be reversed.

X _____
(Patient / Responsible Party-REQUIRED)

Date

X _____
(Witness-REQUIRED, not spouse) _____
Date