Tift Regional Health System offers Financial Assistance programs. For qualified patients, these programs offer full reduction of their hospital bill (Indigent/Charity Care) or reduced monthly payment plans. The criteria for full financial assistance are based on total **gross** income, available assets, and family size. Reduced payment plans can use **net** income. Expenses will be considered for reduced payment plans **only**.

In addition to completing an application, proof of income received from all sources from all in-house family members is required for the Indigent/Charity Care programs **only**. Various types of documentation are accepted as proof of income but not all are required. The types include, but are not limited to:

- **Previous year's tax return (required if claiming any dependents under 21). A Dependent Attestation Form can be used if you did not file taxes the previous year. A Financial Counselor can provide this form or it can be printed from our website listed below.**
- Previous 3 month's pay stubs prior to the date of application (e.g. 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. **Should state the pay rate, pay frequency, and number of hours worked per week.**
- 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 name of the person giving support as well as the relationship to the patient, type of support (e.g. cash, room & board, etc.), and length of support. They should also sign & date the letter. A template statement if available 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.

Home/property owners whose total property value is **$125,000** or more should provide their most recent mortgage statement if applicable (**only** if applying for Indigent/Charity Care programs).

You may be required to apply for other government programs including, but not limited to, Medicaid and Disability prior to receiving Indigent/Charity Care approval.

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 can not be processed until **all** required information is received. Approved applications are valid for twelve (12) months. Individual accounts must meet guidelines per our policy to be eligible. You may request a reconsideration of 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 be covered. To view a complete list of covered and non-covered facilities/locations see Appendix A on our website listed below.

Services that are covered by your insurance plan but are 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 insurance, including liability/auto insurance, must be satisfied prior to applying any adjustments.

Please return all documentation to:

Tift Regional Health System
Attn: Financial Counseling Unit
PO Box 807
Tifton, GA 31793
Fax: 229-353-6908
Website: www.tiftregional.com/FinancialAssistance

Financial Counselors are located in the Physician Center at 907 E18th Street, Suite 190, in Tifton. They are available by phone at 229-353-6124, option 2, to answer questions or assist with the application process. Please allow thirty days from receipt of your completed application (including supporting documents) for processing. We will mail a letter to you once we have made a determination.

Southwell

Financial Assistance Policy Plain Language Summary

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

Southwell 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:

Federal Poverty Level	Amount of Assistance
125%	100%
126%-225%	100%

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

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.tiftregional.com/
- Visit our Financial Counseling office located at:
  Tift Physician Center
  Suite 400
  907 18th Street
  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 to be mailed or sent electronically by calling (229) 353-6124 option 2

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

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 to:
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, a campus of Tift Regional Medical Center (Adel, Georgia)
- Other locations can be found at http://www.tiftregional.com/FinancialAssistance

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.

Tift Regional Health System
Financial Assistance Application

GUARANTOR: _____
(*NO MINORS*) LAST FIRST MIDDLE

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED
(*CIRCLE ONE*)

(*CIRCLE ONE OR BOTH*)
APPLYING FOR: INDIGENT/CHARITY or PAY PLAN
IF PAY PLAN: I CAN PAY $_____ per MONTH
PAYMENT DUE ON: _____DAY of each MONTH

PHYSICIAL ADDRESS: _____ **TELEPHONE NO**: _____

CITY, STATE, ZIP, COUNTY: _____ **EMAIL:**_____

MAILING ADDRESS (*IF DIFFERENT FROM PHYSICIAL*): _____

DO YOU CURRENTLY HAVE INSURANCE: Y / N
IF YES, NAME OF INSURANCE/POLICY #: _____
IF NO, WHEN DID YOU LAST HAVE COVERAGE? _____

DOES YOUR SPOUSE CURRENTLY HAVE INSURANCE: Y / N
IF YES, NAME OF INSURANCE/POLICY #: _____
IF NO, WHEN DID YOU LAST HAVE COVERAGE? _____

LIST ALL HOUSEHOLD MEMBERS INCLUDING YOURSELF, SPOUSE & DEPENDENTS UNDER 21

(SEE ATTACHED/BACK FOR INCOME VERIFICATION & OTHER DOCUMENT REQUIREMENTS)

NAME	RELATIONSHIP	DATE OF BIRTH	SS#	MONTHLY INCOME	
				GROSS	NET
	SELF				

FOR PAY PLANS ONLY-MONTHLY EXPENSES (PAST 3 MONTH AVERAGE) ATTACH SEPARATE PAGE FOR ANY ADDITIONAL EXPENSES:

RENT: $_____ MORTGAGE: $_____
PHONE/INTERNET/CABLE: $_____
GAS/TRANSPORTATION: $_____
AUTO INS: $_____
CHILD CARE: $_____
OTHER MEDICAL: $_____
OTHER: $_____

UTILITIES: _____
GROCERIES: _____
AUTO LOAN: _____
OTHER INS: _____
CREDIT CARDS: _____
PRESCRIPTIONS: $_____
OTHER: _____

FOR INDIGENT/CHARITY ONLY-ASSETS (if left blank it will be counted as zero or as not owned):

HOME VALUE (if own): $_____ OTHER PROPERTY: $_____ COUNTY:_____
VEHICLE(S) VALUE: (1) $_____ (2)$_____ OTHER ASSETS: $_____
CHECKING: $_____ SAVINGS: $_____ OTHER CASH ASSETS: $_____

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**: _____

TRHS STAFF ONLY: ***240 DAY TIMELY FILING DATE:*** _____

INDIGENT/CHARITY: FAMILY SIZE:_____ TOTAL ANNUAL GROSS INCOME: $_____
APPROVED: INDIGENT or CHARITY **DENIED:** OVER INCOME or OVER ASSETS **EXP DATE:** _____
FINANCIAL COUNSELOR: _____ DATE: _____
FINANCIAL COUNSELOR SUPERVISOR: _____ PFS DIRECTOR: _____

RECONSIDERATION: FAMILY SIZE:_____ TOTAL ANNUAL GROSS INCOME: $_____
APPROVED: INDIGENT or CHARITY **DENIED:** OVER INCOME or OVER ASSETS **EXP DATE:** _____
FINANCIAL COUNSELOR: _____ DATE:_____ PFS DIRECTOR: _____

PAY PLAN MONTHLY TOTALS: INCOME: $_____ EXPENSES: $_____ REMAINING: $_____
FINANCIAL COUNSELOR: _____ DATE: _____FC SUPERVISOR:_____ PFS DIRECTOR:_____

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

Current Marital Status	Date of Occurrence	**Documentation Required**
☐ Married/remarried		Marriage certificate ☐ documentation previously submitted to TRHS
☐ Divorced		Court documentation ☐ documentation previously submitted to TRHS
☐ Separated		a) Court document (i.e. legal separation, divorce request) **OR** b) Letter on letterhead from a third party to validate separation (i.e. church official, school official, marriage counselor) **OR** c) Documentation of two physical addresses (i.e. separate utility bills, rent/mortgage with each person's name)
☐ Widowed		Death certificate ☐ documentation previously submitted to TRHS
☐ Never married	N/A	N/A

****Please provide the required documentation when submitting this form.**

☐ 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) Date (Witness-*Required, not spouse*) Date

Revised August 1, 2020