FINANCIAL ASSISTANCE GRID FOR FLUSHING HOSPITAL - EFFECTIVE 01/13/2018

Financial Aid Plan		FA00	FA01		FA02		FA03		FA04	NOCV
FPL		100% or less	101%	To 150%	151%	To 200%	201%	To 250%	251% Plus W/Complete App	Incomplete App/No App
Family Size	Income	Less Than	Greater Than	To	Greater Than	To	Greater Than	To	Greater Than	Incomplete App/No App
1	Annual	12140.00	12140.00	18,210.00	18,210.00	24,280.00	24,280.00	30,350.00	30,350.00	Incomplete App/No App
	Monthly	1012.00	1012.00	1,518.00	1,518.00	2,024.00	2,024.00	2,530.00	2,530.00	Incomplete App/No App
	Weekly	234.00	234.00	351.00	351.00	468.00	468.00	585.00	585.00	Incomplete App/No App
2	Annual	16460.00	16460.00	24,690.00	24,690.00	32,920.00	32,920.00	41,150.00	41,150.00	Incomplete App/No App
	Monthly	1372.00	1372.00	2,058.00	2,058.00	2,744.00	2,744.00	3,430.00	3,430.00	Incomplete App/No App
	Weekly	317.00	317.00	475.50	475.50	634.00	634.00	792.50	792.50	Incomplete App/No App
3	Annual	20780.00	20780.00	31,170.00	31,170.00	41,560.00	41,560.00	51,950.00	51,950.00	Incomplete App/No App
	Monthly	1732.00	1732.00	2,598.00	2,598.00	3,464.00	3,464.00	4,330.00	4,330.00	Incomplete App/No App
	Weekly	400.00	400.00	600.00	600.00	800.00	800.00	1,000.00	1,000.00	Incomplete App/No App
4	Annual	25100.00	25100.00	37,650.00	37,650.00	50,200.00	50,200.00	62,750.00	62,750.00	Incomplete App/No App
	Monthly	2092.00	2092.00	3,138.00	3,138.00	4,184.00	4,184.00	5,230.00	5,230.00	Incomplete App/No App
	Weekly	483.00	483.00	724.50	724.50	966.00	966.00	1,207.50	1,207.50	Incomplete App/No App
5	Annual	29420.00	29420.00	44,130.00	44,130.00	58,840.00	58,840.00	73,550.00	73,550.00	Incomplete App/No App
	Monthly	2452.00	2452.00	3,678.00	3,678.00	4,904.00	4,904.00	6,130.00	6,130.00	Incomplete App/No App
	Weekly	566.00	566.00	849.00	849.00	1,132.00	1,132.00	1,415.00	1,415.00	Incomplete App/No App
6	Annual	33740.00	33740.00	50,610.00	50,610.00	67,480.00	67,480.00	84,350.00	84,350.00	Incomplete App/No App
	Monthly	2812.00	2812.00	4,218.00	4,218.00	5,624.00	5,624.00	7,030.00	7,030.00	Incomplete App/No App
	Weekly	649.00	649.00	973.50	973.50	1,298.00	1,298.00	1,622.50	1,622.50	Incomplete App/No App
7	Annual	38060.00	38060.00	57,090.00	57,090.00	76,120.00	76,120.00	95,150.00	95,150.00	Incomplete App/No App
	Monthly	3172.00	3172.00	4,758.00	4,758.00	6,344.00	6,344.00	7,930.00	7,930.00	Incomplete App/No App
	Weekly	732.00	732.00	1,098.00	1,098.00	1,464.00	1,464.00	1,830.00	1,830.00	Incomplete App/No App
8	Annual	42380.00	42380.00	63,570.00	63,570.00	84,760.00	84,760.00	105,950.00	105,950.00	Incomplete App/No App
	Monthly	3532.00	3532.00	5,298.00	5,298.00	7,064.00	7,064.00	8,830.00	8,830.00	Incomplete App/No App
	Weekly	815.00	815.00	1,222.50	1,222.50	1,630.00	1,630.00	2,037.50	2,037.50	Incomplete App/No App
For each additional family member, add $4,320 to annual income level.										

Outpatient Rates

Service Type	FA00	FA01	FA02	FA03	FA04	NOCV
Ambulance (ALS)	$150	$150	$150	$150	$150	$150
Ambulance (BLS)	$150	$150	$150	$150	$150	$150
Medical Emergency Room	$15 (see note 5)	20% of Medicaid APG	40% of Medicaid APG	60% of Medicaid APG	80% of Medicaid APG	100% of Medicaid APG
Mental Health ER Brief Visit	$15 (see note 5)	$36	$72	$108	$144	$181
Mental Health ER Full Evaluation	$15 (see note 5)	$212	$424	$636	$848	$1,060
Mobile Crisis Outreach/Interim Unit	$15 (see note 5)	$212	$424	$636	$848	$1,060
Mental Health Observation Rate	$150.00 per discharge	20% of Medicaid Rate	40% of Medicaid Rate	60% of Medicaid Rate	80% of Medicaid Rate	100% of Medicaid Rate
Dental Emergency (See Note 11)	5% of Medicaid APG	20% of Medicaid APG	40% of Medicaid APG	60% of Medicaid APG	80% of Medicaid APG	100% of Medicaid APG
Medical Clinic Rates	$15 (see note 5)	$20	$40	$60	$80	$120
Mental Health Clinic Rate	$5	$8	$16	$24	$32	$48
Mental Health Clinic Group Rate	$5	$5	$8	$12	$16	$24
Nutrition Initial	$5	$20	$40	$60	$80	$100
Nutrition Reassessment	$5	$14	$28	$42	$56	$70
Nutrition Group (30 min)	$5	$6	$12	$18	$24	$30
PT/OT/ST	$5	$20	$40	$60	$80	$120
Chemo Therapy (see note 7)	$5	$20	$40	$60	$80	$120
Referred Ambulatory	5% of Medicaid Fee Schedule	20% of Medicaid Fee Schedule	40% of Medicaid Fee Schedule	60% of Medicaid Fee Schedule	80% of Medicaid Fee Schedule	100% of Medicaid Fee Schedule
PST / APST	5% of Medicaid Fee Schedule	20% of Medicaid Fee Schedule	40% of Medicaid Fee Schedule	60% of Medicaid Fee Schedule	80% of Medicaid Fee Schedule	100% of Medicaid Fee Schedule
Amb Surgery (per procedure)	$150 per procedure	20% of Medicaid APG	40% of Medicaid APG	60% of Medicaid APG	80% of Medicaid APG	100% of Medicaid APG
Inpatient Rates						
Acute Inpatient Services	$150.00 per discharge	20% of Medicaid Rate	40% of Medicaid Rate	60% of Medicaid Rate	80% of Medicaid Rate	100% of Medicaid Rate
Psych Inpatient Services	$150.00 per discharge	20% of Medicaid Rate	40% of Medicaid Rate	60% of Medicaid Rate	80% of Medicaid Rate	100% of Medicaid Rate
Normal Delivery	$150.00 per discharge	20% of Medicaid Rate	40% of Medicaid Rate	60% of Medicaid Rate	80% of Medicaid Rate	100% of Medicaid Rate
C-Section Delivery	$150.00 per discharge	20% of Medicaid Rate	40% of Medicaid Rate	60% of Medicaid Rate	80% of Medicaid Rate	100% of Medicaid Rate
Newborn (see note 6)	$150.00 per discharge	20% of Medicaid Rate	40% of Medicaid Rate	60% of Medicaid Rate	80% of Medicaid Rate	100% of Medicaid Rate
Rehab I/P Services	$150.00 per discharge	$262 per diem	$524 per diem	$786 per diem	$ 1048 per diem	$1310 per diem

1. All rates for outpatient, inpatient and obstetrics services exclude anesthesia, DME, prescription drugs and/or physician fees.
2. For all FA/NOCV plans: If total charges are less than the applicable % of Medicaid rate, the patient is only obligated to pay the the lesser of the two amounts associated with the designated Financial Aid Plan or NOCV - but never more than facility total charges.
3. Referred Ambulatory and PST/APST services not listed on Medicaid fee schedule will be billed at respective percentage of facility charge amounts for FA/NOCV patients.
4. If a patient cancels or is a no-show for an elective procedure and either the PST or APST was performed, the patient is financially responsible for those tests. The patient will be billed based on the applicable % of Medicaid rate associated with the patient's respective FA/NOCV plan, or % of total charges if Medicaid rate does not exist.
5. Per NYS-DOH regulations, patient/responsible party will not be charged or billed for prenatal or pediatric ER/Clinic services registered under FA00 plan.
6. Newborn rates will apply separately from mom. In the event of multiple births, individual rates will apply for each additional newborn.
7. Medically-Necessary Implants/Chemo Drugs: In the absence of a Medicaid fee schedule, patients are responsible for the designated % of COST associated with their respective FA/NOCV plan.
8. For all FA/NOCV plans, ROUTINE ancillary procedures are included in the clinic flat rate when ordered by facility physician at prior clinic visit.
9. When an FA/NOCV patient returns for their ROUTINE ancillary test on a different day, the insurance code FANV should be used for FA patients, and NONV for NOCV patients.
10. Services/Procedures that are not considered medically-necessary, and not reimbursed by Medicaid, are subject to Self-Pay rates at facility total charges - not FA/NOCV rates.
11. Only emergency dental services are covered under the Financial Assistance Program. All other dental services are subject to Dental Self-Pay Fee Schedule.