FINANCIAL AID GRID FOR JAMAICA HOSPITAL - EFFECTIVE 03/24/2021

Financial Assistance Plan		FA00	FA01		FA02		FA03		FA04	NOCV
Federal Poverty Guidelines		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 or Equal To	Greater Than	To	Greater Than	To	Greater Than	To	Greater Than	Incomplete App/No App
1	Annual	12880.00	12880.00	19,320.00	19,320.00	25,760.00	25,760.00	32,200.00	32,200.00	Incomplete App/No App
	Monthly	1073.00	1073.00	1,609.50	1,609.50	2,146.00	2,146.00	2,682.50	2,682.50	Incomplete App/No App
	Weekly	247.00	247.00	370.50	370.50	494.00	494.00	617.50	617.50	Incomplete App/No App
2	Annual	17420.00	17420.00	26,130.00	26,130.00	34,840.00	34,840.00	43,550.00	43,550.00	Incomplete App/No App
	Monthly	1451.00	1451.00	2,176.50	2,176.50	2,902.00	2,902.00	3,627.50	3,627.50	Incomplete App/No App
	Weekly	335.00	335.00	502.50	502.50	670.00	670.00	837.50	837.50	Incomplete App/No App
3	Annual	21960.00	21960.00	32,940.00	32,940.00	43,920.00	43,920.00	54,900.00	54,900.00	Incomplete App/No App
	Monthly	1830.00	1830.00	2,745.00	2,745.00	3,660.00	3,660.00	4,575.00	4,575.00	Incomplete App/No App
	Weekly	422.00	422.00	633.00	633.00	844.00	844.00	1,055.00	1,055.00	Incomplete App/No App
4	Annual	26500.00	26500.00	39,750.00	39,750.00	53,000.00	53,000.00	66,250.00	66,250.00	Incomplete App/No App
	Monthly	2208.00	2208.00	3,312.00	3,312.00	4,416.00	4,416.00	5,520.00	5,520.00	Incomplete App/No App
	Weekly	509.00	509.00	763.50	763.50	1,018.00	1,018.00	1,272.50	1,272.50	Incomplete App/No App
5	Annual	31040.00	31040.00	46,560.00	46,560.00	62,080.00	62,080.00	77,600.00	77,600.00	Incomplete App/No App
	Monthly	2586.00	2586.00	3,879.00	3,879.00	5,172.00	5,172.00	6,465.00	6,465.00	Incomplete App/No App
	Weekly	596.00	596.00	894.00	894.00	1,192.00	1,192.00	1,490.00	1,490.00	Incomplete App/No App
6	Annual	35580.00	35580.00	53,370.00	53,370.00	71,160.00	71,160.00	88,950.00	88,950.00	Incomplete App/No App
	Monthly	2965.00	2965.00	4,447.50	4,447.50	5,930.00	5,930.00	7,412.50	7,412.50	Incomplete App/No App
	Weekly	684.00	684.00	1,026.00	1,026.00	1,368.00	1,368.00	1,710.00	1,710.00	Incomplete App/No App
7	Annual	40120.00	40120.00	60,180.00	60,180.00	80,240.00	80,240.00	100,300.00	100,300.00	Incomplete App/No App
	Monthly	3343.00	3343.00	5,014.50	5,014.50	6,686.00	6,686.00	8,357.50	8,357.50	Incomplete App/No App
	Weekly	771.00	771.00	1,156.50	1,156.50	1,542.00	1,542.00	1,927.50	1,927.50	Incomplete App/No App
8	Annual	44660.00	44660.00	66,990.00	66,990.00	89,320.00	89,320.00	111,650.00	111,650.00	Incomplete App/No App
	Monthly	3721.00	3721.00	5,581.50	5,581.50	7,442.00	7,442.00	9,302.50	9,302.50	Incomplete App/No App
	Weekly	858.00	858.00	1,287.00	1,287.00	1,716.00	1,716.00	2,145.00	2,145.00	Incomplete App/No App

For each additional family member, add $4,480 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)	20% of Medicaid Rate	40% of Medicaid Rate	60% of Medicaid Rate	80% of Medicaid Rate	100% of Medicaid Rate
Mental Health ER Full Evaluation	$15 (see note 5)	20% of Medicaid Rate	40% of Medicaid Rate	60% of Medicaid Rate	80% of Medicaid Rate	100% of Medicaid Rate
Mobile Crisis Outreach/Interim Unit	$15 (see note 5)	20% of Medicaid Rate	40% of Medicaid Rate	60% of Medicaid Rate	80% of Medicaid Rate	100% of Medicaid Rate
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
MRI	$150 per test	20% of Medicaid APG	40% of Medicaid APG	60% of Medicaid APG	80% of Medicaid APG	100% of Medicaid APG
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

Service Type	FA00	FA01	FA02	FA03	FA04	NOCV
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

NOTE:

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 Aid Program. All other dental services are subject to Dental Self-Pay Fee Schedule.