FINANCIAL AID GRID FOR JAMAICA HOSPITAL - EFFECTIVE 06/10/2020

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	12760.00	12760.00	19,140.00	19,140.00	25,520.00	25,520.00	31,900.00	31,900.00	Incomplete App/No App
	Monthly	1063.00	1063.00	1,594.50	1,594.50	2,126.00	2,126.00	2,657.50	2,657.50	Incomplete App/No App
	Weekly	245.00	245.00	367.50	367.50	490.00	490.00	612.50	612.50	Incomplete App/No App
2	Annual	17240.00	17240.00	25,860.00	25,860.00	34,480.00	34,480.00	43,100.00	43,100.00	Incomplete App/No App
	Monthly	1436.00	1436.00	2,154.00	2,154.00	2,872.00	2,872.00	3,590.00	3,590.00	Incomplete App/No App
	Weekly	332.00	332.00	498.00	498.00	664.00	664.00	830.00	830.00	Incomplete App/No App
3	Annual	21720.00	21720.00	32,580.00	32,580.00	43,440.00	43,440.00	54,300.00	54,300.00	Incomplete App/No App
	Monthly	1810.00	1810.00	2,715.00	2,715.00	3,620.00	3,620.00	4,525.00	4,525.00	Incomplete App/No App
	Weekly	418.00	418.00	627.00	627.00	836.00	836.00	1,045.00	1,045.00	Incomplete App/No App
4	Annual	26200.00	26200.00	39,300.00	39,300.00	52,400.00	52,400.00	65,500.00	65,500.00	Incomplete App/No App
	Monthly	2183.00	2183.00	3,274.50	3,274.50	4,366.00	4,366.00	5,457.50	5,457.50	Incomplete App/No App
	Weekly	504.00	504.00	756.00	756.00	1,008.00	1,008.00	1,260.00	1,260.00	Incomplete App/No App
5	Annual	30680.00	30680.00	46,020.00	46,020.00	61,360.00	61,360.00	76,700.00	76,700.00	Incomplete App/No App
	Monthly	2557.00	2557.00	3,835.50	3,835.50	5,114.00	5,114.00	6,392.50	6,392.50	Incomplete App/No App
	Weekly	590.00	590.00	885.00	885.00	1,180.00	1,180.00	1,475.00	1,475.00	Incomplete App/No App
6	Annual	35160.00	35160.00	52,740.00	52,740.00	70,320.00	70,320.00	87,900.00	87,900.00	Incomplete App/No App
	Monthly	2930.00	2930.00	4,395.00	4,395.00	5,860.00	5,860.00	7,325.00	7,325.00	Incomplete App/No App
	Weekly	676.00	676.00	1,014.00	1,014.00	1,352.00	1,352.00	1,690.00	1,690.00	Incomplete App/No App
7	Annual	39640.00	39640.00	59,460.00	59,460.00	79,280.00	79,280.00	99,100.00	99,100.00	Incomplete App/No App
	Monthly	3303.00	3303.00	4,954.50	4,954.50	6,606.00	6,606.00	8,257.50	8,257.50	Incomplete App/No App
	Weekly	762.00	762.00	1,143.00	1,143.00	1,524.00	1,524.00	1,905.00	1,905.00	Incomplete App/No App
8	Annual	44120.00	44120.00	66,180.00	66,180.00	88,240.00	88,240.00	110,300.00	110,300.00	Incomplete App/No App
	Monthly	3677.00	3677.00	5,515.50	5,515.50	7,354.00	7,354.00	9,192.50	9,192.50	Incomplete App/No App
	Weekly	848.00	848.00	1,272.00	1,272.00	1,696.00	1,696.00	2,120.00	2,120.00	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
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

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.