FINANCIAL AID GRID FOR JAMAICA HOSPITAL - EFFECTIVE 01/30/2023

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	14580.00	14580.00	21,870.00	21,870.00	29,160.00	29,160.00	36,450.00	36,450.00	Incomplete App/No App
	Monthly	1215.00	1215.00	1,822.50	1,822.50	2,430.00	2,430.00	3,037.50	3,037.50	Incomplete App/No App
	Weekly	280.00	280.00	420.00	420.00	560.00	560.00	700.00	700.00	Incomplete App/No App
2	Annual	19720.00	19720.00	29,580.00	29,580.00	39,440.00	39,440.00	49,300.00	49,300.00	Incomplete App/No App
	Monthly	1643.00	1643.00	2,464.50	2,464.50	3,286.00	3,286.00	4,107.50	4,107.50	Incomplete App/No App
	Weekly	379.00	379.00	568.50	568.50	758.00	758.00	947.50	947.50	Incomplete App/No App
3	Annual	24860.00	24860.00	37,290.00	37,290.00	49,720.00	49,720.00	62,150.00	62,150.00	Incomplete App/No App
	Monthly	2071.00	2071.00	3,106.50	3,106.50	4,142.00	4,142.00	5,177.50	5,177.50	Incomplete App/No App
	Weekly	478.00	478.00	717.00	717.00	956.00	956.00	1,195.00	1,195.00	Incomplete App/No App
4	Annual	30000.00	30000.00	45,000.00	45,000.00	60,000.00	60,000.00	75,000.00	75,000.00	Incomplete App/No App
	Monthly	2500.00	2500.00	3,750.00	3,750.00	5,000.00	5,000.00	6,250.00	6,250.00	Incomplete App/No App
	Weekly	576.00	576.00	864.00	864.00	1,152.00	1,152.00	1,440.00	1,440.00	Incomplete App/No App
5	Annual	35140.00	35140.00	52,710.00	52,710.00	70,280.00	70,280.00	87,850.00	87,850.00	Incomplete App/No App
	Monthly	2928.00	2928.00	4,392.00	4,392.00	5,856.00	5,856.00	7,320.00	7,320.00	Incomplete App/No App
	Weekly	675.00	675.00	1,012.50	1,012.50	1,350.00	1,350.00	1,687.50	1,687.50	Incomplete App/No App
6	Annual	40280.00	40280.00	60,420.00	60,420.00	80,560.00	80,560.00	100,700.00	100,700.00	Incomplete App/No App
	Monthly	3356.00	3356.00	5,034.00	5,034.00	6,712.00	6,712.00	8,390.00	8,390.00	Incomplete App/No App
	Weekly	774.00	774.00	1,161.00	1,161.00	1,548.00	1,548.00	1,935.00	1,935.00	Incomplete App/No App
7	Annual	45420.00	45420.00	68,130.00	68,130.00	90,840.00	90,840.00	113,550.00	113,550.00	Incomplete App/No App
	Monthly	3785.00	3785.00	5,677.50	5,677.50	7,570.00	7,570.00	9,462.50	9,462.50	Incomplete App/No App
	Weekly	873.00	873.00	1,309.50	1,309.50	1,746.00	1,746.00	2,182.50	2,182.50	Incomplete App/No App
8	Annual	50560.00	50560.00	75,840.00	75,840.00	101,120.00	101,120.00	126,400.00	126,400.00	Incomplete App/No App
	Monthly	4213.00	4213.00	6,319.50	6,319.50	8,426.00	8,426.00	10,532.50	10,532.50	Incomplete App/No App
	Weekly	972.00	972.00	1,458.00	1,458.00	1,944.00	1,944.00	2,430.00	2,430.00	Incomplete App/No App

For families/households with more than 8 persons, add $5,140 for each additional person.

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

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	$264 per diem	$528 per diem	$792 per diem	$ 1056 per diem	$1321 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.