FINANCIAL AID GRID FOR JAMAICA HOSPITAL - EFFECTIVE 04/01/2019

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	12490.00	12490.00	18,735.00	18,735.00	24,980.00	24,980.00	31,225.00	31,225.00	Incomplete App/No App
	Monthly	1041.00	1041.00	1,561.50	1,561.50	2,082.00	2,082.00	2,602.50	2,602.50	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	16910.00	16910.00	25,365.00	25,365.00	33,820.00	33,820.00	42,275.00	42,275.00	Incomplete App/No App
	Monthly	1409.00	1409.00	2,113.50	2,113.50	2,818.00	2,818.00	3,522.50	3,522.50	Incomplete App/No App
	Weekly	325.00	325.00	487.50	487.50	650.00	650.00	812.50	812.50	Incomplete App/No App
3	Annual	21330.00	21330.00	31,995.00	31,995.00	42,660.00	42,660.00	53,325.00	53,325.00	Incomplete App/No App
	Monthly	1778.00	1778.00	2,667.00	2,667.00	3,556.00	3,556.00	4,445.00	4,445.00	Incomplete App/No App
	Weekly	410.00	410.00	615.00	615.00	820.00	820.00	1,025.00	1,025.00	Incomplete App/No App
4	Annual	25750.00	25750.00	38,625.00	38,625.00	51,500.00	51,500.00	64,375.00	64,375.00	Incomplete App/No App
	Monthly	2146.00	2146.00	3,219.00	3,219.00	4,292.00	4,292.00	5,365.00	5,365.00	Incomplete App/No App
	Weekly	495.00	495.00	742.50	742.50	990.00	990.00	1,237.50	1,237.50	Incomplete App/No App
5	Annual	30170.00	30170.00	45,255.00	45,255.00	60,340.00	60,340.00	75,425.00	75,425.00	Incomplete App/No App
	Monthly	2514.00	2514.00	3,771.00	3,771.00	5,028.00	5,028.00	6,285.00	6,285.00	Incomplete App/No App
	Weekly	580.00	580.00	870.00	870.00	1,160.00	1,160.00	1,450.00	1,450.00	Incomplete App/No App
6	Annual	34590.00	34590.00	51,885.00	51,885.00	69,180.00	69,180.00	86,475.00	86,475.00	Incomplete App/No App
	Monthly	2883.00	2883.00	4,324.50	4,324.50	5,766.00	5,766.00	7,207.50	7,207.50	Incomplete App/No App
	Weekly	665.00	665.00	997.50	997.50	1,330.00	1,330.00	1,662.50	1,662.50	Incomplete App/No App
7	Annual	39010.00	39010.00	58,515.00	58,515.00	78,020.00	78,020.00	97,525.00	97,525.00	Incomplete App/No App
	Monthly	3251.00	3251.00	4,876.50	4,876.50	6,502.00	6,502.00	8,127.50	8,127.50	Incomplete App/No App
	Weekly	750.00	750.00	1,125.00	1,125.00	1,500.00	1,500.00	1,875.00	1,875.00	Incomplete App/No App
8	Annual	43430.00	43430.00	65,145.00	65,145.00	86,860.00	86,860.00	108,575.00	108,575.00	Incomplete App/No App
	Monthly	3619.00	3619.00	5,428.50	5,428.50	7,238.00	7,238.00	9,047.50	9,047.50	Incomplete App/No App
	Weekly	835.00	835.00	1,252.50	1,252.50	1,670.00	1,670.00	2,087.50	2,087.50	Incomplete App/No App

For each additional family member, add $4,420 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.