FINANCIAL ASSISTANCE GRID FOR FLUSHING HOSPITAL - EFFECTIVE 02/28/2024

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	15060.00	15060.00	22,590.00	22,590.00	30,120.00	30,120.00	37,650.00	37,650.00	Incomplete App/No App
	Monthly	1255.00	1255.00	1,882.50	1,882.50	2,510.00	2,510.00	3,137.50	3,137.50	Incomplete App/No App
	Weekly	290.00	290.00	435.00	435.00	580.00	580.00	725.00	725.00	Incomplete App/No App
2	Annual	20440.00	24440.00	36,660.00	36,660.00	48,880.00	48,880.00	61,100.00	61,100.00	Incomplete App/No App
	Monthly	1704.00	1704.00	2,556.00	2,556.00	3,408.00	3,408.00	4,260.00	4,260.00	Incomplete App/No App
	Weekly	394.00	394.00	591.00	591.00	788.00	788.00	985.00	985.00	Incomplete App/No App
3	Annual	25820.00	25820.00	38,730.00	38,730.00	51,640.00	51,640.00	64,550.00	64,550.00	Incomplete App/No App
	Monthly	2152.00	2152.00	3,228.00	3,228.00	4,304.00	4,304.00	5,380.00	5,380.00	Incomplete App/No App
	Weekly	497.00	497.00	745.50	745.50	994.00	994.00	1,242.50	1,242.50	Incomplete App/No App
4	Annual	31200.00	31200.00	46,800.00	46,800.00	62,400.00	62,400.00	78,000.00	78,000.00	Incomplete App/No App
	Monthly	2600.00	2600.00	3,900.00	3,900.00	5,200.00	5,200.00	6,500.00	6,500.00	Incomplete App/No App
	Weekly	600.00	600.00	900.00	900.00	1,200.00	1,200.00	1,500.00	1,500.00	Incomplete App/No App
5	Annual	36580.00	36580.00	54,870.00	54,870.00	73,160.00	73,160.00	91,450.00	91,450.00	Incomplete App/No App
	Monthly	3049.00	3049.00	4,573.50	4,573.50	6,098.00	6,098.00	7,622.50	7,622.50	Incomplete App/No App
	Weekly	704.00	704.00	1,056.00	1,056.00	1,408.00	1,408.00	1,760.00	1,760.00	Incomplete App/No App
6	Annual	41960.00	41960.00	62,940.00	62,940.00	83,920.00	83,920.00	104,900.00	104,900.00	Incomplete App/No App
	Monthly	3497.00	3497.00	5,245.50	5,245.50	6,994.00	6,994.00	8,742.50	8,742.50	Incomplete App/No App
	Weekly	807.00	807.00	1,210.50	1,210.50	1,614.00	1,614.00	2,017.50	2,017.50	Incomplete App/No App
7	Annual	47340.00	47340.00	71,010.00	71,010.00	94,680.00	94,680.00	118,350.00	118,350.00	Incomplete App/No App
	Monthly	3945.00	3945.00	5,917.50	5,917.50	7,890.00	7,890.00	9,862.50	9,862.50	Incomplete App/No App
	Weekly	911.00	911.00	1,366.50	1,366.50	1,822.00	1,822.00	2,277.50	2,277.50	Incomplete App/No App
8	Annual	52720.00	52720.00	79,080.00	79,080.00	105,440.00	105,440.00	131,800.00	131,800.00	Incomplete App/No App
	Monthly	4394.00	4394.00	6,591.00	6,591.00	8,788.00	8,788.00	10,985.00	10,985.00	Incomplete App/No App
	Weekly	1014.00	1014.00	1,521.00	1,521.00	2,028.00	2,028.00	2,535.00	2,535.00	Incomplete App/No App
For each additional family member, add $5,380 to annual income level.										

Outpatient Rates

Service Type	FA00	FA01	FA02	FA03	FA04	NOCV
Ambulance (BLS)	$13	$50	$100	$150	$200	$250
Ambulance (ALS1)	$15	$60	$119	$178	$237	$296
Ambulance (ALS2)	$22	$86	$172	$258	$344	$429
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
Emergency Room Observation Rate	$150.00 per discharge	20% of Medicaid APG	40% of Medicaid APG	60% of Medicaid APG	80% of Medicaid APG	100% of Medicaid APG
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 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 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.
11. Only emergency dental services are covered under the Financial Assistance Program. All other dental services are subject to Dental Self-Pay Fee Schedule.
12. For FA rates that calculate to an amount less than the flat FA00 amount for a procedure/service, the patient will be responsible to pay the flat FA00 amount for the same procedure/service.