FINANCIAL ASSISTANCE GRID FOR FLUSHING HOSPITAL - EFFECTIVE 07/16/2024

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	Total Charges
Ambulance (ALS1)	$15	$60	$119	$178	$237	Total Charges
Ambulance (ALS2)	$22	$86	$172	$258	$344	Total Charges
Medical Emergency Room	$15 (see note 5)	20% of Medicaid APG	40% of Medicaid APG	60% of Medicaid APG	80% of Medicaid APG	Total Charges
Emergency Room Observation Rate	$150.00 per discharge	20% of Medicaid APG	40% of Medicaid APG	60% of Medicaid APG	80% of Medicaid APG	Total Charges
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	Total Charges
Medical Clinic Rates	$15 (see note 5)	$20	$40	$60	$80	Total Charges
Mental Health Clinic Rate	$5	$8	$16	$24	$32	Total Charges
Mental Health Clinic Group Rate	$5	$5	$8	$12	$16	Total Charges
Nutrition Initial	$5	$20	$40	$60	$80	Total Charges
Nutrition Reassessment	$5	$14	$28	$42	$56	Total Charges
Nutrition Group (30 min)	$5	$6	$12	$18	$24	Total Charges
PT/OT/ST	$5	$20	$40	$60	$80	Total Charges
Chemo Therapy (see note 7)	$5	$20	$40	$60	$80	Total Charges
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	Total Charges
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	Total Charges
MRI	$150 per test	20% of Medicaid Fee Schedule	40% of Medicaid Fee Schedule	60% of Medicaid Fee Schedule	80% of Medicaid Fee Schedule	Total Charges
Amb Surgery (per procedure)	$150 per procedure	20% of Medicaid APG	40% of Medicaid APG	60% of Medicaid APG	80% of Medicaid APG	Total Charges

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	Total Charges
Psych Inpatient Services	$150.00 per discharge	20% of Medicaid Rate	40% of Medicaid Rate	60% of Medicaid Rate	80% of Medicaid Rate	Total Charges
Normal Delivery	$150.00 per discharge	20% of Medicaid Rate	40% of Medicaid Rate	60% of Medicaid Rate	80% of Medicaid Rate	Total Charges
C-Section Delivery	$150.00 per discharge	20% of Medicaid Rate	40% of Medicaid Rate	60% of Medicaid Rate	80% of Medicaid Rate	Total Charges
Newborn (see note 6)	$150.00 per discharge	20% of Medicaid Rate	40% of Medicaid Rate	60% of Medicaid Rate	80% of Medicaid Rate	Total Charges
Rehab I/P Services	$150.00 per discharge	$262 per diem	$524 per diem	$786 per diem	$ 1048 per diem	Total Charges

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.
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 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 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 plan.
8. For all FA plans, ROUTINE ancillary procedures are included in the clinic flat rate when ordered by facility physician at prior clinic visit.
9. When an FA patient returns for their ROUTINE ancillary test on a different day, the insurance code FANV should be used for FA 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.