



Unit # _____

Patient Name: _____

Freeman Financial Assistance Decision Tree

<input type="checkbox"/> Patient has been denied State or Federal programs or is deemed ineligible for such based on such guidelines.	<input type="checkbox"/> Patient or guarantor meets FPG guidelines FPG = _____%
<input type="checkbox"/> Account is in good standing *(Not in BD status)	<input type="checkbox"/> Services are Emergent or Proof of Medical Necessity from physician attached

Poverty Guidelines 2024				
Persons in family	100%	150%	200%	250%
1	15,060	22,590	30,120	37,650
2	20,440	30,660	40,880	51,100
3	25,820	38,730	51,640	64,550
4	31,200	46,800	62,400	78,000
5	36,580	54,870	73,160	91,450
6	41,960	62,940	83,920	104,900
7	47,340	71,010	94,680	118,350
8	52,720	79,080	105,440	131,800

*** For each additional family member above 8, add \$5,140 to FPG percentage.*

	Less than 100% FPL	101- 200% FPL	201 - 250% FPL	
Discount:	100%	100% after copay met	AGB after copay met	
Patient's Responsibility:	Co-pay = 0.00 Out of pocket = 0.00	Co-pay	Co-pay + AGB%	**PD copay not to exceed Hemo mnlthly copay amounts under 101
Co-pays:	Hospitals	Physicians	Home Health	Health Essentials
	Inpatient: \$200 per visit	Office Visit: \$25 per visit	Home Care: \$25.00 per visit	\$50 Per Rental per Month
	Outpatient \$50 per visit	Inpatient Visit: \$100 per stay	Home Infusion \$ 40 per visit	Group 3 Chairs
	Urgent Care \$50 per visit	Therapy \$10 per visit Outpatient facility Srvs \$50.00	Medical Equipment \$20 per piece	\$500-\$1,000
	Emergency \$75 per visit	Phys professional Srvs \$25.00	Dialysis PT 10.00 per tx PD PT 5.00 per tx	*Copay for chair depends on Functionality

Catastrophic Events:

Catastrophic Assistance: In a case-by-case basis Financial Assistance may be taken into consideration where a patient may not ordinarily qualify for Financial Assistance based off of FPG alone.

Application is Complete with following required supporting documents and or statements attached:

***Proof or credible statements supporting lack of housing / homelessness may void requirements listed below.**

- Proof of identity (Driver's license or other Photo Id with patient/guarantor address)
- Proof of current Income (Copy of employer(s) check stubs)
- Proof of yearly Income (Copy of current year or previous year's income)
- Proof of business/self-employed Income (Copy of current year or previous year's income tax)
- Proof of any other income

Charity Application is approved for a _____% write off based on _____ %FPG.

Patient responsibility after FAA adjustment \$ _____

Charity Application is denied due to:

- Above FPG guidelines of 250%
- Failure to provide financial verifications
- Statements deemed invalid
- Account is in BD status greater than 120 days
- Services are not Medically Emergent or Deemed Necessary by treating physician

FHS Representative: _____ Date _____ Signature _____

of reviewer deems all statements and verifications are valid and accurate based on information provided and to the best of their knowledge. **FFA decision determination is valid for 90 days from signature date: pre/post.** <https://aspe.hhs.gov/poverty-guidelines>