FREEMAN
Health System

Unit # ______________________________

Patient Name: ______________________________

Freeman Financial Assistance Decision Tree

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

Poverty Guidelines 2021

Persons in family	100%	150%	200%	250%
1	12,880	19,320	25,760	32,200
2	17,420	26,130	34,840	43,550
3	21,960	32,940	43,920	54,900
4	26,500	39,750	53,000	66,250
5	31,040	46,560	62,080	77,600
6	35,580	53,370	71,160	88,950
7	40,120	60,180	80,240	100,300
8	44,660	66,990	89,320	111,650

*** For each additional family member above 8, add $5,680 to FPG percentage.*

	Less than 100% FPL	101- 200% FPL	201 - 250% FPL	
Discount:	100%	100% after copay met	78% after copay met	
Patient's Responsibility:	Co-pay = 0.00 Out of pocket = 0.00	Co-pay	Co-pay + 22%	
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		*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 (Drivers 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**