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 2019				
Persons in family	100%	150%	200%	250%
1	$12,490	$18,735	$24,980	$31,225
2	$16,910	$25,365	$33,820	$42,275
3	$21,330	$31,995	$42,660	$53,325
4	$25,750	$38,625	$51,500	$64,375
5	$30,170	$45,255	$60,340	$75,425
6	$34,590	$51,885	$69,180	$86,475
7	$39,010	$58,515	$78,020	$97,525
8	$43,430	$65,145	$86,860	$108,575

*** For each additional family member above 8, add $4,320 to FPG percentage*

	Less than 100% FPL	**101- 200% FPL**	**201 - 250% FPL**	
Discount:	100%	100% after copay met	75% after copay met	
Patient's Responsibility:	Co-pay = 0.00 Out of pocket = 0.00	Co-pay	Co-pay + 25%	
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 employers 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**