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 2025

Persons in family	100%	150%	200%	250%
1	15,650	23,475	31,300	39,125
2	21,150	31,725	42,300	52,875
3	26,650	39,975	53,300	66,625
4	32,150	48,225	64,300	80,375
5	37,650	56,475	75,300	94,125
6	43,150	64,725	86,300	107,875
7	48,650	72,975	97,300	121,625
8	54,150	81,225	108,300	135,375

*** For each additional family member above 8, add $5,500 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 mnthly 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 in BD status greater than 120 days
- ☐ Services are not Medically Emergent or Deemed Necessary by treating physicians

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**