FINANCIAL ASSISTANCE POLICY SUMMARY

Holy Cross Hospital is committed to being a transforming, healing presence in the communities we serve. Aligned with our core value of Reverence for Each Person, we provide care for persons who are in need and give special consideration to those who are most vulnerable, including those who are unable to pay and those whose limited means make it extremely difficult to meet the expenses incurred in receiving health care.

The purpose is to establish guidelines for Financial Assistance for patients within our service area who incur significant financial burden as a result of the amount they are expected to owe “out-of-pocket” for acute health care services.

CRITERIA & ELIGIBILITY

A 100% discount for medically necessary services is available to uninsured patients who earn 200% or less of the Federal Poverty Level guidelines. Individuals who earn between 200% and 400% of the Federal Poverty Level guidelines are eligible for a partial discount equal to the Medicare discount rate. Supporting documentation such as payroll stubs, credit history and tax returns, along with certain levels and certain types of patient/family assets, may be considered to determine financial need.

Elective services such as cosmetic surgery are not included in our charity program.

Patient copays, deductibles, and coinsurance may be eligible for discounted rates if a patient qualifies for financial assistance and earns less than 200% of the Federal Poverty Level Guidelines.

Financial Assistance is also available for those patients who are facing catastrophic costs associated with their medical care. Catastrophic costs occur when a patient’s medical expenses for an episode of care exceed 20% of their annual income. In these cases, patient copays and deductibles may also be included in the discount.

Financial Assistance may be denied if patients are eligible for other funding sources such as a Health Insurance Exchange plan (Marketplace) or Medicaid eligibility and refuse (or are unwilling) to apply for these sources.

APPLYING

To apply for financial assistance, please submit the completed application (and all supplemental information) to our Financial Assistance Coordinator located in the hospital. The complete Financial Assistance Policy and Application may be found on our website at http://www.holy-cross.com/billing-insurance. This application may also be requested and submitted by mail or by visiting/calling our Financial Counseling Department at 954-267-7771. The Financial Assistance Application and Policy are also available in Spanish.
PATIENT FINANCIAL SERVICES

Financial counselors are available to work with patients in completing financial assistance applications to determine what assistance is available. This includes assessing eligibility for Medicaid and Health Insurance Exchange plans.

Patients may contact a financial counselor at the hospital where they receive care who can assist in determining qualification for financial assistance.

No patient who qualifies for financial assistance will be charged more than the amounts generally billed by the hospital, which are Medicare rates.

THE HEALTH INSURANCE MARKETPLACE

The Affordable Care Act (ACA) requires everyone legally living in the U.S. to have health insurance beginning January 1, 2014. It also gives millions of individuals (with too little or no insurance) access to health plans at different cost levels. The law also provides financial assistance to those who qualify based on family size and income.

Please see one of our Health Insurance Marketplace Navigators located in the hospital or set up an appointment by calling 954-678-3910 or by emailing FLNavigator1@apallc.com.
PURPOSE:

Holy Cross Hospital (HCH) is a member of the CHE Trinity system. CHE Trinity Health is a community of persons serving together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. Aligned with our Core Values, in particular that of Commitment To Those Who Are Poor, we provide care for persons who are in need and give special consideration to those who are most vulnerable, including those who are unable to pay and those whose limited means make it extremely difficult to meet the health care expenses incurred. HCH is committed to:

- Providing access to quality health care services with compassion, dignity and respect for those we serve, particularly the poor and the underserved in our communities;
- Caring for all persons, regardless of their ability to pay for services; and
- Assisting patients who cannot pay for part or all of the care that they receive.

DEFINITIONS:

Emergent (service level) - Medical services needed for a condition that may be life threatening or the result of a serious injury and requiring immediate medical attention. This medical condition is generally governed by Emergency Medical Treatment and Active Labor Act (EMTALA).

Family - As defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a patient claims someone as a dependent on their income tax return, according to the Internal Revenue Service rules, they may be considered a dependent for the purpose of determining eligibility.

Income - Income includes wages, salaries, salary and self-employment income, unemployment compensation, worker's compensation, payments from Social Security, public assistance, veteran’s benefits, child support, alimony, educational assistance, survivor’s benefits, pensions,
retirement income, regular insurance and annuity payments, income from estates and trusts, rents received, interest/dividends, and income from other miscellaneous sources.

**Family Income** - A person’s family income includes the income of all adult family members in the household. For patients under 18 years of age, family income includes that of the parents and/or step-parents, or caretaker relatives. Annual income from the prior 12 month period or the prior tax year as shown by recent pay stubs or income tax returns and other information. Proof of earnings may be determined by annualizing the year-to-date family income, taking into consideration the current earnings rate.

**Financial Support** - Support (charity, discounts, etc.) provided to patients for whom it would be a hardship to pay for the full cost of medically necessary services provided by HCH who meet the eligibility criteria for such assistance.

**Uninsured Patient** - An individual who is uninsured, having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), Worker’s Compensation, or other third party assistance to cover all or part of the cost of care, including claims against third parties covered by insurance to which HCH is subrogated, but only if payment is actually made by such insurance company.

**Urgent (service level)** - Medical services for a condition not life-threatening, but requiring timely medical services.

**Service Area** – A service area is the list of zip codes comprising the HCH primary and secondary service market area constituting a “community of need” for primary health care services.

**PROCEDURE:**

1. **Qualifying Criteria for Financial Assistance**

   This Financial Assistance Policy (FAP) is designed to address the need for financial assistance and support to patients for all eligible services regardless of race, creed, sex, or age. Eligibility for financial assistance and support from HCH will be determined on an individual basis using specific criteria and evaluated on an assessment of the patient’s and/or family’s health care needs, financial resources and obligations.

   a. Services eligible for financial support:

      i. All medically necessary services, including medical and support services provided by HCH, will be eligible for financial support.

      ii. Emergency medical care services will be provided to all patients who present to the HCH emergency department, regardless of the patient’s ability to pay. Such medical care will continue until the patient’s condition has been stabilized prior to any determination of payment arrangements.

   b. Services not eligible for financial support:
i. Cosmetic services, other elective procedures and services that are not medically necessary.

ii. Services not provided and billed by HCH or HCH employed physicians (e.g. independent physician services, private duty nursing, ambulance transport, etc.).

iii. HCH will make affirmative efforts to help patients apply for public and private programs. Financial support may be denied to those individuals who do not cooperate in applying for programs that may pay for their health care services.

iv. Services may be excluded that are covered by an insurance program at another provider location but are not covered at HCH, after efforts are made to educate the patients and provided that federal Emergency Medical Treatment and Active Labor Act (EMTALA) obligations are satisfied.

c. Residency requirements

i. Financial support will be provided to patients who reside within the HCH primary or secondary service area and qualify under this FAP.

ii. Financial support will be provided to patients from outside the HCH primary or secondary service area who qualify under this FAP and who present with an emergent or life-threatening condition.

iii. Financial support will be provided to patients identified as needing service by physician foreign mission programs conducted by active medical staff.

d. Documentation for Establishing Income

i. The Statement of Financial Condition will be used to document each patient’s overall financial situation.

ii. Supporting documents such as payroll stubs, tax returns, and credit history may be requested to support information reported and shall be maintained with the completed application and assessment.

iii. Certain types and certain levels of patient/family assets may be considered as a source of payment.

e. Presumptive Support

i. HCH recognizes that not all patients are able to provide complete financial information. Therefore, approval for financial support may be determined based on limited available information. When such approval is granted it is classified as “Presumptive Support.”

ii. Examples of presumptive cases include:
   - deceased patients with no known estate
   - homeless
• unemployed patients
• non-covered medically necessary services provided to patients qualifying for public assistance programs
• patient bankruptcies, and
• members of religious organizations who have taken a vow of poverty and have no resources individually or through the religious order.

iv. For the purpose of helping financially needy patients, a third-party may be utilized to conduct a review of patient information to assess financial need. This review utilizes a health care industry-recognized, predictive model that is based on public record databases. These public records enable HCH to assess whether the patient is characteristic of other patients who have historically qualified for financial assistance under the traditional application process. In cases where there is an absence of information provided directly by the patient, and after efforts to confirm coverage availability are exhausted, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.

f. Timeline for Establishing Financial Eligibility

i. Every effort will be made to determine a patient’s eligibility for financial support prior to or at the time of admission or service. Financial assistance applications will be accepted until one year after the first billing statement to the patient.

ii. Determination for financial support will be made after all efforts to qualify the patient for governmental financial assistance or other programs have been exhausted.

iii. Every effort will be made to make a financial support determination in a timely fashion. If other avenues of financial support are being pursued, HCH will communicate with the patient regarding the process and expected timeline for determination and shall not attempt collection efforts while such determination is being made.

iv. Once qualification for financial support has been determined, subsequent reviews for continued eligibility for subsequent services will be made every 90 days.

g. Level of Financial Support

i. A percentage of the Federal Poverty Guidelines (FPG), which are updated on an annual basis, will be used for determining a patient’s eligibility for financial support. However, other factors, as identified above, will be considered such as the patient’s financial status and/or ability to pay as determined through the assessment process.

iv. Family Income at or below 200% of Federal Poverty Income Guidelines:

• A full discount off total charges will be provided for uninsured patients whose family’s income is at or below 200% of the most recent Federal Poverty Guidelines.
v. Family Income between 201% and 400% of Federal Poverty Income Guidelines:

- A discount off total charges equal to the average HCH acute care contractual adjustment for Medicare will be provided for acute care patients whose family income is between 201% and 400% of Federal Poverty Income Guidelines. A discount off total charges equal to the HCH physician contractual adjustment for Medicare will be provided for ambulatory patients whose family income is between 201% and 400% of Federal Poverty Income Guidelines.

vi. Patients with Family Income up to and including 200% of the Federal Poverty Income Guidelines will be eligible for Financial Support for co-pay and deductible amounts provided that there is no conflict with contractual arrangements with the patient’s insurer and that they apply for financial assistance.

vii. Medically Indigent Support / Catastrophic: Financial support is also provided for medically indigent patients. Medical indigence occurs when a person is unable to pay some or all of their medical bills because their medical expenses exceed a certain percentage of their family or household income (for example, due to catastrophic costs or conditions), regardless of whether they have income or assets that otherwise exceed the financial eligibility requirements for free or discounted care. Catastrophic costs or conditions occur when there is a loss of employment, death of primary wage earner, excessive medical expenses or other unfortunate events. Medical indigence / catastrophic circumstances will be evaluated on a case-by-case basis that includes a review of the patient’s income, expenses and assets. If an insured patient claims catastrophic circumstances and applies for financial assistance, medical expenses for an episode of care that exceed 20% of income will permit co-pays and deductibles to qualify as catastrophic charity care. Discounts for medically indigent care for the uninsured will not be less than the average contractual adjustment amount for Medicare for the services provided or an amount to bring the patient’s catastrophic medical expense-to-income ratio back to 20%. Medical indigent and catastrophic financial assistance must be approved by the HCH Chief Financial Officer (CFO).

viii. While financial support should be made in accordance with the established written criteria, it is recognized that occasionally there will be a need for granting additional financial support to patients based upon individual considerations. Such individual considerations must be approved by the HCH CFO.

II. Assisting Patients Who May Qualify for Coverage

HCH will make affirmative efforts to help patients apply for public and private programs for which they may qualify and that may assist them in obtaining and paying for health care services.

III. Effective Communications

a. HCH will provide financial counseling to patients about their health care bills related to the services they received at HCH and will make the availability of such counseling known.
b. HCH will respond promptly and courteously to patients’ questions about their bills and requests for financial assistance.

c. HCH will utilize a billing process that is clear, concise, correct and patient friendly.

d. HCH will make available for review by the public specific information in an understandable format about what it charges for services.

e. HCH will post signs and display brochures that provide basic information about its Financial Assistance Policy (FAP) in public locations.

f. HCH will make the Financial Assistance Policy (FAP), a plain language summary of the FAP and the FAP application form available to patients upon request, in public places in HCH, by mail and on the HCH website.

g. This policy will be made available in English and in the primary language of any population with limited proficiency in English that constitutes more than 10 percent of the residents of the community served by HCH. HCH will list on their website and in the CFO’s office the locations where these documents are available.

IV. Implementation of Accurate and Consistent Policies

a. Patient Financial Services and Patient Access will educate staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections, physician offices) about billing, financial assistance, collection policies and practices, and treatment of all patients with dignity and respect regardless of their insurance status or their ability to pay for services.

V. Fair Billing and Collection Practices

a. HCH will implement billing and collection practices for the patient payment obligations that are fair, consistent and compliant with state and federal regulations.

b. HCH will make available to all patients who qualify a short term interest free payment plan with defined payment time frames based on the outstanding account balance. HCH will also offer a loan program for patients who qualify.

c. Patient balances will be transferred to a collection agency if the account completes a patient statement cycle (e.g. 120 days) with no payment from the patient or proof of eligibility for financial assistance or other programs.

d. The following collection activities may be pursued by HCH or by a collection agent on their behalf:

i. Communicate with patients (call, written, fax, text, email, etc.) and their representatives in compliance with the Fair Debt Collections Act, clearly identifying HCH. The patient communications will also comply with HIPAA privacy regulations.
ii. Solicit payment of the estimated patient payment obligation portion at the time of service in compliance with EMTALA regulations and state laws.

iii. Report outstanding debts to Credit Bureaus only after all aspects of this procedure have been applied and after reasonable collection efforts have been made in conformance with this FAP.

iv. Pursue legal action for individuals who have the means to pay but do not pay or who are unwilling to pay. Legal action requires approval from the HCH CFO.

v. Place liens on property of individuals who have the means to pay but do not or who are unwilling to pay. Placement of lien requires approval by the HCH CFO.
REQUIRED DOCUMENTATION FOR FINANCIAL ASSISTANCE ELIGIBILITY

Patient Name ____________________________  Account Number ____________________________

A copy of your entire Income Taxes or 1099 forms for the year of ________________.

*Note: If you did not file taxes for the previous year, please contact the IRS at 1-800-829-1040 and obtain a letter of “Non-Filing for __________” or go to www.irs.gov/pub/irs-fill/f4506*

A copy of your most recent bank statements reflecting all transactions for the last three (3) months. Documentation must be in the bank’s statement format and must include name, address, and account number. All pages are required. Please include all checking accounts and savings accounts.

Copy of your most recent payroll check stub or a letter from your employer documenting your salary. If you are unemployed, we require a copy of your Unemployment Compensation Benefits Determination Letter.

Alimony or Child Support Determination Letter(s)      Check one □ Yes   □ No

Food Stamp Determination Letter      Check one □ Yes   □ No

Letter from Social Security/Disability/Pension documenting the income benefit amount you are currently receiving monthly (if applicable)

Completed and signed Application Form (attached)

Completed, signed, and notarized (by a Notary Public) Attestation Form.

*Note: Notary service is available at Holy Cross Hospital

Completed, signed, and notarized Support Letter by your guarantor or person(s) supporting you

Apply for Medicaid. Provide Approval or Denial Determination Letter.

Medicaid website: www.myflorida.com/accessflorida or call 866-762-2237

Copy of valid photo identification – Driver’s License, Passport, Work ID. The photograph must be clear and the identification not expired.

Proof of residency in the Service Area (rental agreement, utility bill, invoice). See Holy Cross Hospital Service Area matrix.

Completed, signed and notarized No Financial Banking Affidavit Form

Apply for the insurance through the Affordable Care Act Health Insurance Marketplace at www.healthcare.gov or call 800-318-2596. Provide the determination letter.

Explanation of bank statements with cash deposits or withdraws of amounts greater than $200.

All of the information above is required to process your Request for Financial Assistance.

Your Financial Assistance Application will not be considered if the required documents are not delivered within 20 days.

Financial Assistance/Charity Coordinator ____________________________  Mailing Date of Request ____________________________

954-267-7780

Version 8-14
STATEMENT OF FINANCIAL CONDITION

Section 1: Demographic Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Social Security Number</th>
<th>Date of Birth</th>
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<th>Alternate Telephone #</th>
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<th>Zip Code</th>
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Section 2: Employer Information

<table>
<thead>
<tr>
<th>Your Employer Name</th>
<th>Employer Telephone #</th>
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<table>
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<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tr>
<th>Spouse Employer Name</th>
<th>Spouse Employer Telephone #</th>
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<th>City</th>
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<th>Zip Code</th>
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Section 3: Income & Expense Information

<table>
<thead>
<tr>
<th>Last 12 Months Gross Income</th>
<th>Patient</th>
<th>Spouse</th>
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<tbody>
<tr>
<td>Gross Income</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Other Family Income</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Interest &amp; Dividends</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Real Estate or Personal Property</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Social Security</td>
<td>$</td>
<td>$</td>
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<tr>
<td>State Financial Assistance</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Other Income (specify)</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Alimony or Child Support Payments</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Current Monthly Income</td>
<td>$</td>
<td>$</td>
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<tr>
<td>Total Combined Income</td>
<td>$</td>
<td>$</td>
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<table>
<thead>
<tr>
<th>Expenses</th>
<th>Monthly</th>
<th>Payment</th>
</tr>
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<tbody>
<tr>
<td>Rent</td>
<td>Own</td>
<td>Monthly</td>
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<tr>
<td>Utilities</td>
<td>Monthly</td>
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<tr>
<td>Food</td>
<td>Monthly</td>
<td>$</td>
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<tr>
<td>Other Expenses</td>
<td>Monthly</td>
<td>$</td>
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<tr>
<td>Total Monthly Expenses</td>
<td>$</td>
<td></td>
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Other Considerations

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<thead>
<tr>
<th>Other Considerations</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Family Size: _______________________</td>
<td></td>
<td></td>
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<tr>
<td>Child Care/Babysitter</td>
<td></td>
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<tr>
<td>Single Parent Caring for Elders</td>
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<tr>
<td>Cost to Provide Services Exceeds 3rd Party Reimbursement</td>
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<tr>
<td>Emergency Services</td>
<td></td>
<td></td>
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<tr>
<td>If patient is deceased, is there an estate</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Was your medical condition a result of an accident or injury?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you retained an attorney (If yes, list name and phone #)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

By signing this form I agree to allow Holy Cross Hospital and/or Holy Cross medical group to check employment and credit history for the purpose of determining my eligibility for financial assistance or a financial discount. I understand that I may be required to provide proof of the information listed on the application. I certify that the above information is true and accurate to the best of my knowledge. Further, I understand that I am to apply for any assistance via State County or federal funding, which may be available for payment of my hospital visit, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this charity application applies only to the dates of service and corresponding account numbers referenced on this application for Holy Cross Hospital and Holy Cross Medical Group and that I may incur additional charges from other professional entities of which I will be responsible including but not limited to Anesthesiologists, Radiologists and Pathologists. Unless patient requires a course of treatment based on one diagnosis a new, charity form must be submitted for every date of service.

Applicant's Signature __________________________ Date of Request __________

Reviewed By __________________________ Date of Review __________

Version 8-14
FINANCIAL ASSISTANCE INCOME INDIGENCY ATTESTATION STATEMENT

Patient Name  Account Number

I,________________________________ certify, under the penalty of law that my family income for the past twelve (12) months has been $___________, and that there are ____ people in my household/immediate family. I certify that I reside in the following zip code _____________ and _______________ (Country).

This income can be verified by calling the following employer(s):

<table>
<thead>
<tr>
<th>Company Name</th>
<th>Telephone #</th>
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</table>

*Note: Write ‘Unemployed’ if not employed

Additionally, I understand that in accordance with S.817.50, providing false information to defraud a hospital for the purpose of obtaining goods and services is a misdemeanor in the second degree.

By signing this form, I agree to allow Holy Cross Hospital to check employment and credit history for the purpose of determining my eligibility for financial assistance or a financial discount.

Guarantor Printed Name  Guarantor Signature/Date

Witness Printed Name  Witness Signature/Date

Witness Relationship to Patient

State of Florida
County of Broward

The foregoing instrument was acknowledged by before me this ______________________________ by ______________________________, who is personally known to me or who has proved ______________________________ as identification and who did/did not take an oath.

Notary Public  Date
NO FINANCIAL BANKING AFFIDAVIT

_________________________________________  ______________________________________
Patient Name                                    Account Number

I certify that

I do____ I do not____ have a Bank Account anywhere in the United States of America.

_________________________________________  ______________________________
Signature                                      Date

State of Florida
County of Broward
Subscribed and sworn to me before this_________________ day of ____________________
__________________________________________, who is personally known to me or who has proved
__________________________________________ as identification and who did/did not take an oath.

_________________________________________  ______________________________
Notary Public                                  Date

Version 8-14
LETTER OF SUPPORT

_________________________________________  ___________________________________________
Patient Name                                               Account Number

This is to certify that I ____________________________ being the ____________________________

Name                                                        Relationship

of the above patient, do provide free room at board at __________________________________________

for the past ________ years/months.

Check the box of the living expenses that you provide:

Rent □  Mortgage □  Food □  Clothes □  
Utilities □  Car Insurance □  Gas □  Medicine □  
Money □

Cash Assistance

How much money was given to the patient on a weekly or monthly basis  $ ____________________________

How long was the patient provided with the money ____________________________________________

_________________________________________  ________________________________
Signature Of Supporter                                                Date

State of Florida
County of Broward

Subscribed and sworn to me before this____________________day of ________________________
_________________________________________________ , who is personally known to me or who has proved
_________________________________________________ as identification and who did/did not take an oath.

_________________________________________  ________________________________
Notary Public                                                Date
## 2014 Federal Poverty Guidelines

*The 2014 Federal Poverty Guidelines apply to all states and for the District of Columbia (except Alaska and Hawaii)*

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Federal Poverty Guideline (FPG)</th>
<th>If income is below 200% (shown below) of FPG → eligible for <strong>Full Financial Assistance</strong></th>
<th>If income is above 200% but below 400% (shown below) of FPG → eligible for <strong>Partial Financial Assistance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,670</td>
<td>$23,340</td>
<td>$46,680</td>
</tr>
<tr>
<td>2</td>
<td>$15,730</td>
<td>$31,460</td>
<td>$62,920</td>
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<tr>
<td>3</td>
<td>$19,790</td>
<td>$39,580</td>
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<td>$23,850</td>
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<td>$95,400</td>
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<tr>
<td>5</td>
<td>$27,910</td>
<td>$55,820</td>
<td>$111,640</td>
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<tr>
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<td>$31,970</td>
<td>$63,940</td>
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</tr>
<tr>
<td>7</td>
<td>$36,030</td>
<td>$72,060</td>
<td>$144,120</td>
</tr>
<tr>
<td>8</td>
<td>$40,090</td>
<td>$80,180</td>
<td>$160,360</td>
</tr>
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</table>

For family units of more than 8 members, add $4,060 for each additional member.

The Federal Poverty Guidelines document will be updated annually.

For more information, please visit [www.medicaid.gov](http://www.medicaid.gov).
2014 HOLY CROSS HOSPITAL SERVICE AREAS

*A service area is the list of zip codes comprising the Holy Cross Hospital primary and secondary service market area constituting a "community of need" for primary health care services.

<table>
<thead>
<tr>
<th>Primary Service Area</th>
<th>Secondary Service Area</th>
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The Holy Cross Hospital Primary and Secondary Service Areas will be reviewed annually.