FINANCIAL ASSISTANCE

DRAFTED BY: Tara Pizzi, Manager Financial Counseling CNE	PAGE: 1 of 12	EFFECTIVE DATE: October 1, 2024	POLICY NUMBER: CNE – FIN - 102
	REVIEWED BY: Andrew Burke, Finance Director CNE	REVIEWED BY: Krysten Blanchette, VP Revenue Cycle CNE	APPROVED BY: Todd Conklin, EVP, Chief Financial Officer CNE

I. **Purpose.** The purpose of this Financial Assistance Policy (FAP) is to ensure that Care New England (hereafter identified as CNE) is in compliance with the standards set by the State of Rhode Island and Federal Agencies for the Provision of Charity Care and section §501(r) of the Internal Revenue Code. Financial assistance is intended to ensure all patients receive essential emergency and other medically necessary healthcare services provided by CNE regardless of their ability to pay. To that end, CNE will assist individuals who do not otherwise have the ability to pay charges as determined under CNE's qualification criteria and considers each individual's ability to contribute to the cost of his or her care. CNE financial assistance is not intended to serve as a substitute for employer-sponsored, privately purchased, third party liability, state or federally funded assistance or insurance programs.

II. **Scope.** This Policy applies to Care New England (CNE) and all Care New England hospitals, and the specified entities as defined below:

a. Butler Hospital
b. Kent Hospital
c. Women & Infants Hospital
d. The Providence Center**
e. VNA of Care New England
f. Butler Hospital Allied Medical Services, LLC
g. Kent Ancillary Services, LLC
h. W&I Ancillary Services, LLC
i. W&I Health Care Alliance, LLC
j. Affinity Physicians, LLC
k. Faculty Physicians Incorporated, LLC

A listing of additional providers who elect to follow CNE's Financial Assistance Plan as well as those providers who do not participate (Participating and Non-Participating Providers) is defined in Exhibit 1.

** The Providence Center (TPC) is included as a CNE entity in this policy, however, TPC also has a policy outlining specific application requirements as a Community Mental Health Center (TPC-FIN-103).

III. **Policy.** All patients will be provided treatment for all emergent and medically necessary healthcare services regardless of their ability to pay as outlined in the CNE Emergency Medical Treatment and Active Labor Act (EMTALA) Policy. Copies of this policy may be obtained, free of charge, by calling CNE's Compliance Department at (401) 277-3660.

a. The decision to extend financial assistance is based solely on the applicant's financial status as indicated by pre-determined eligibility requirements and will be granted to all qualifying patients, regardless of race, color, religion, age, national origin, marital status, or legally protected status. This policy will be uniformly applied to any patients having no insurance or inadequate health insurance.
b. Patients are eligible for financial assistance for emergent and all medically necessary healthcare services. Medically necessary healthcare services are defined as hospital services that are reasonably required to make a diagnosis, to correct, cure, alleviate, or prevent the worsening of conditions that endanger life or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the person requesting the service.
c. Patients who qualify for CNE Charity Care are eligible for discounted or free prescription coverage. The prescription must be pursuant and related to care provided by a CNE 340B Covered Entity (Acute Care Hospitals within the Care New England System). When the elements of the 340B patient definition (as set forth by HRSA) are met, a 340B medication may be utilized.

IV. **Definitions.** Capitalized terms not otherwise defined below but used in this Policy shall have the meanings assigned to them in this Policy.

a. *Amounts Generally Billed (AGB):* Pursuant to Internal Revenue Code ("IRC") §501(r)(5), in the case of emergency or other medically necessary care, the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care.
b. *Amounts Generally Billed Percentage:* A percentage of gross charges that a hospital facility uses to determine the AGB for any emergency or other medically necessary care it provides to an individual who is eligible for assistance under this FAP.
c. *Application Period:* The time period in which an individual may apply for financial assistance. To satisfy the criteria outlined in IRC §501(r)(6), CNE allows individuals up to 240 days from the date the individual is provided with the first post-discharge billing statement to apply for financial assistance.

d. *Eligibility Criteria:* The criteria set forth in this FAP (and supported by procedure) used to determine whether or not a patient qualifies for financial assistance.
e. *Emergency medical conditions:* Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).
f. *Extraordinary Collection Actions ("ECAs"):* Includes any of the following actions taken by CNE against an individual related to obtaining payment of a bill for care covered under this FAP. ECAs include, but are not limited to, actions that require a legal or judicial process, reporting adverse information to consumer credit reporting agencies or credit bureaus, placing of a lien and/or foreclosing on real property, attaching, or seizing a bank account or garnishment of wages, and deferring, denying, or requiring payment prior to providing non-emergency medical care due to nonpayment of debt for previously provided care covered under the Policy.
g. *Family:* Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, civil union, or adoption.
h. *Family Income:* Family Income is determined using the Census Bureau definition, which uses the following income when computing poverty guidelines:
    i. Income earnings, unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous resources.
i. *FAP-eligible*: Individuals who are eligible for full or partial financial assistance under this policy.
j. *Federal Poverty Level Guidelines*: The federal poverty level guidelines ("FPL") are established by the United States Department of Health and Human Services on an annual basis and are used within this FAP for determining financial eligibility.
k. *Financial Assistance*: Free or discounted healthcare services offered to individuals who are unable to pay for all or a portion of their medical services.
l. *Gross Charges*: The full established price for medical care that is consistently and uniformly charged to patients before applying any contractual allowances, discounts, or deductions.
m. *Plain Language Summary* ("*PLS*"): A written statement which notifies an individual that CNE offers financial assistance under this FAP and provides additional information in a clear, concise, and easy to understand manner.
n. *Underinsured*: An individual who has some level of insurance or third-party coverage, but still has out-of-pocket healthcare costs that exceed their financial abilities. Underinsurance includes, but is not limited to, deductibles, coinsurance, co-payments, exhausted benefits, and lifetime benefit limits.
o. *Uninsured*: An individual who has no level of insurance or third-party coverage, including Medicare, Medicaid, or any other government or commercial insurance program, to help pay for healthcare services.
p. *Non-covered services:* Services that are not covered under the patient's benefits / insurance plan and therefore will not be paid by the patient's insurance plan.

V. Procedure.

a. Patients having no health insurance or inadequate health insurance coverage are eligible to apply for the program. To be considered for financial assistance under the Financial Assistance Policy, the patient and/or legal representative must submit a complete Financial Assistance Application (including related documents/information) (Exhibit 2) and must cooperate with CNE by providing the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care, such as Medicare, Medicaid, RItecare, third party liability, etc.

b. CNE's Financial Assistance Policy, Plain Language Summary (PLS), application form and required documents are available on CNE's website: www.carenewengland.org. Additionally, individuals may, at no charge, request documents by mail, by calling (401) 921-7200.

c. Additionally, CNE will publicize this FAP and the PLS in the entities we serve. Financial Assistance may be accessed as follows:
    i. Patients or their representatives may request financial assistance
    ii. CNE employees may refer patients or their representatives
    iii. Referring physicians may refer patients or their representative

d. Full financial assistance will be granted to patients whose gross family income is less than or equal to 200% of the Federal Poverty Levels (FPL), adjusted for family size, provided such patients are not eligible for other private or public health coverage and do not exceed the assets protection threshold. In cases where the patient/guarantor qualifies for Financial Assistance under the income criterion but does not meet the assets criterion, CNE will provide the highest discount offered under the sliding scale. The maximum liability to the patient/guarantor will be the actual assets less the applicable asset thresholds or the maximum cap limitations as defined by Rhode Island and Federal regulations, including IRS §501(r), whichever is less (Exhibit 3).

e. Patients with gross income between 201% and 300% of the FPL and who do not exceed the assets protection threshold are also eligible for financial assistance for a portion of the medical bill, based upon a sliding scale (Exhibit 3). The patient's financial responsibility is subject to maximum cap limitations as defined by Rhode Island State and Federal Regulations including IRS §501(r) or as periodically set by CNE. The maximum liability charged to the patient/guarantor will not exceed the lesser of AGB, state law or whichever other criteria set by CNE. Information related to the limitations set by CNE as well as the sliding scale may be obtained free of charge by calling CNE Customer Service at (401) 921-7200.

f. CNE will follow established collection procedures to obtain payment from individuals with a financial obligation after application of the sliding fee schedule as outlined in the CNE Billing and Collections Policy. Uninsured patients will be notified of Financial Assistance at discharge. All patients, insured and uninsured, will also be notified of the FAP through the patient billing statement process for 120 days after the first post-discharge billing statement for care ("Notification Period").

Additionally, individuals may request Financial Assistance documents by mail, by calling (401) 921-7200, or in-person at any of the CNE Hospital locations.

g. To be eligible for 100% financial assistance or partial financial assistance, the maximum liquid assets (excluding a primary residence and personal automobile) shall not exceed the thresholds as indicated on the Sliding Scale for individuals and family units and increased annually in accordance with the most current Consumer Price Index. In the event that these thresholds prevent an individual's ability to qualify for Rhode Island's Medical Assistance program(s), CNE will replace those thresholds with those utilized by Rhode Island's Medical Assistance program(s). Rhode Island Medical Assistance thresholds can be found online at: http://medicaid4you.com/eligibility-requirements.
    i. A family unit, using the Census Bureau definition, is a group of two or more people who reside together and who are related by birth, marriage, civil union, or adoption.
    ii. The amount or percent of the total charges collected on the private pay portion will be equal to or less than the Amount Generally Billed (AGB) (Exhibit 4) as defined: Pursuant to Internal Revenue Code ("IRC") §501(r)(5), in the case of emergency or other medically necessary care, the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care.
    iii. If an incomplete FAP application is received, CNE will provide the individual with written noticethat describes the additional information or documentation required to make a FAP-eligible decision, along with the Plain Language Summary (PLS), and allow the individual 30 days to provide the information. CNE will also suspend any ECA's to obtain payment for care during this time. Individuals will be provided a phone number to call with any questions regarding the additional information or documentation required. Documentation requirements are outlined in Exhibit 5.
    iv. Exceptions that exceed the standard policy benefits must be approved by the Vice President of Revenue Cycle Management or his/her designee.
h. The patient/guarantor may appeal a denial of eligibility for financial assistance by providing additional verification of income or family size within 30 days of receipt of notification of denial. All appeals will be reviewed by the Vice President of Revenue Cycle Management or her/his designee for final determination. By CNE definition, an appeal requires a review by a management level at least one grade higher than that of the original reviewer. A request for appeal must be processed within 30 days from receipt of an appeal request. Written notification of the appeal results must be provided to the patient/guarantor.
i. Amount Collected: The amount or percent of the total charges collected on the private pay portion will not be greater than the Amount Generally Billed (AGB) as stipulated in the IRS §501(r)(5) regulation.
j. If a patient is uninsured and meets the criteria to qualify for an uninsured discount as defined in the CNE Credit Policy, the maximum liability charged to the

patient/guarantor will not exceed the lesser of AGB, state law or whichever other criteria set by CNE.

i. Discount Programs:

1. Community Benefit Discount: All uninsured patients receive a 65% discount for medicallynecessary services regardless of their ability to pay.
2. Advance Payment Discount: All uninsured patients are eligible to receive a 70% discountfor payment of the expected liability prior to or on the date of service. This discount will apply to any additional unexpected liability provided that the patient remits payment in full within thirty (30) days of the final bill. In the event that the payment of the expected liability exceeded the liability, CNE will issue a refund to the patient no later than 30 daysafter the charges are finalized.
3. Prompt Payment Discount: All uninsured patients not already benefiting from the advancepayment discount are eligible for a 10% discount on their balance, provided that the patientremits payment in full within thirty (30) days of the final bill.

k. CNE reserves the right to revoke financial assistance if it determines a patient has knowingly misrepresented their financial condition, the number of dependents or any other information necessary to determine financial status for purposes of this policy.

l. The 'Notice of Hospital Financial Aid' will be available on CNE websites, patient bills and upon request. It will also be posted in Emergency Departments, main lobbies, offices and in admission/registration areas throughout CNE.

m. The Financial-Aid Criteria must be available in other languages in accordance with the applicable "Standards for Culturally and Linguistically Appropriate Services in Health Care" (Standards 4 & 7, based on Title VI of the Civil Rights Act of 1964). They must be approved by the Director and made available to all persons on request. CNE will make every effort to ensure that policies are clearly communicated to patients whose primary languages are languages other than those already provided. Translation services may be provided upon request.

APPROVAL/REVISION:

05/03/2018: Initial Version of Policy approved
10/01/2020: Revision approved
06/21/2021: Revision approved
10/01/2021: Revision approved
10/01/2022: Revision approved
12/01/2023: Revision approved
12/01/2024: Revision approved

REPLACES:
Finance 1

Financial Assistance Policy

Exhibit 1

Participating Providers	Non-Participating Providers
Carcieri MD, David	Atlantic Pediatric
Children Medical Group	Boudjourk MD, Jason
Deangelis MD, Charles	Foot and Ankle of NE Gallucci DPM, Robert
East Bay Pediatric and Adolescent	Greenwich Podiatry
Kent Ophthalmology Vann MD, William	Leonard, Polly
Koster MD, Michael Pediatric Infectious Disease	Radiation therapy Services
McGoldrick MD, Karen	Simmons MD, Rachel
Osteopathic Family Medicine Way DO, Aaron	Urologic Specialty of NE
Rhode Island Imagin	North Main radiation Oncology
Rompf, Patricia MD	Joseph-Delvecchio MD, Jane
Welba, Georgette -Sunshine Pediatrics	
Segal DPM, Kenneth	

Financial Assistance Policy

Exhibit 2

APPLICATION FOR HOSPITAL FINANCIAL AID

Any approval of this request is temporary and expires 12 months from date of approval

Hospital: ☐ Butler ☐ Kent ☐ Memorial ☐ The Providence Center ☐ Women & Infants	Date:
Patient:	Guarantor/Spouse:
MR#:	MR#:
Date of Birth:	Social Security # (if issued):
Social Security # (if issued):	Home Phone:
Home Phone:	Work Phone:
Work Phone:	Relation to Patient:
Home Address:	Address:
Occupation & Employer:	
Employer Address:	

Language: ☐ English ☐ Non-English

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ No Ethnicity Identified

Race: ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other or Multiple Races ☐ No Race Identified

Please provide the following information for ALL members of the family unit, EXCEPT the Patient or Guarantor.			
Name & Relationship to Patient:	SS# (if issued):	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		
Name & Relationship to Patient:	SS# (if issued):	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		
Name & Relationship to Patient:	SS# (if issued):	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		
Name & Relationship to Patient:	SS# (if issued)	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		

MONTHLY INCOME	ASSETS
Patient's Salary & Wages:	Savings:
Spouse's Salary & Wages:	Checking:
Guarantor's Salary & Wages:	Certificates of Deposit (CDs):
Self-Employment Income:	Money Market Accounts:
Child Care Income:	Savings Bonds:
Rental Income:	Stocks:
Unemployment Compensation:	Bonds:
Temporary Disability Insurance:	Mutual Funds:
Child Support:	IRAs:
Alimony:	401(k)s:
Workers' Compensation:	403(b)s:
VA Benefits:	457s:
Social Security Payments:	Cash-In Value Life Insurance:
Dividend & Interest Income:	Personal Property:
Royalties:	2nd Home & Rental Property:
Pensions:	2nd Motor Vehicle:
Public Assistance:	TOTAL:
Other:	
MONTHLY INCOME:	
ANNUAL INCOME:	

"I request the hospital to make a determination of eligibility for financial aid. I understand that this information is confidential and subject to verification by the hospital. I also understand that if the information I provide is false, I may be denied financial aid and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities."

Patient's Signature: _____ Date: _____

Hospital Representative's Signature: _____ Date: _____

Financial Assistance Policy

Exhibit 2 continued

APPLICATION FOR HOSPITAL FINANCIAL AID-*UNDERINSURED*

Any approval of this request is temporary and expires 12 months from date of approval

Hospital: ☐ Butler ☐ Kent ☐ Memorial ☐ The Providence Center ☐ Women & Infants Date:

Patient:	Guarantor/Spouse:
MR#:	MR#:
Date of Birth:	Social Security # (if issued):
Social Security # (if issued):	Home Phone:
Home Phone:	Work Phone:
Work Phone:	Relation to Patient:
Home Address:	Address:
Occupation & Employer:	
Employer Address:	

Language: ☐ English ☐ Non-English

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ No Ethnicity Identified

Race: ☐ Asian ☐ American Indian/Alaska Native ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other or Multiple Races ☐ No Race Identified

Please provide the following information for ALL members of the family unit, EXCEPT the Patient or Guarantor.

Name & Relationship to Patient:	SS# (if issued):	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		
Name & Relationship to Patient:	SS# (if issued):	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		
Name & Relationship to Patient:	SS# (if issued):	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		
Name & Relationship to Patient:	SS# (if issued)	Date of Birth:	MR#:
Employer, Phone & Address:	Home Address:		

MONTHLY INCOME	AMT	ASSETS	AMT	MONTHLY EXPENSES/LIABILITIES	AMT
Patient's Salary & Wages		Savings		Mortgage or Rent Payment	
Spouse's Salary & Wages		Checking		Current Balance _____	
Guarantor's Salary & Wages		Certificates of Deposit (CDs)		Property Taxes if not included in mortgage payment	
Self-Employment Income		Money Market Accounts		Utilities: Gas/Electric/Oil _____	
Child Care Income		Savings Bonds		Cable/Internet _____	
Rental Income		Stocks		Phone _____	
Unemployment Compensation		Bonds		Auto Payments or Lease Payments	
Temporary Disability Insurance		Mutual Funds		Current Balance _____	
Child Support		IRAs		Credit Card Payments	
Alimony		401(k)s		Current Balance _____	
VA Benefits		403(b)s		Installment Loans	
Social Security Payments		457s		Current Balance _____	
Dividend & Interest Income		Cash-In Value Life Insurance		Auto Insurance	
Royalties		Personal Property		Homeowners Insurance	
Pensions		2nd Home & Rental Property		Medical Expenses	
Public Assistance		Additional Motor Vehicles		Groceries	
Other				Other Expenses	
MONTHLY INCOME:					
ANNUAL INCOME:		TOTAL:		TOTAL:	

"I request the hospital to make a determination of eligibility for financial aid. I understand that this information is confidential and subject to verification by the hospital. I also understand that if the information I provide is false, I may be denied financial aid and be liable for payment for the hospital services provided. I hereby attest that the information in this application is complete and correct to the best of my knowledge and that I understand the process and my responsibilities."

Patient's Signature: _____ Date: _____

Hospital Representative's Signature: _____ Date: _____

Financial Assistance Policy

Exhibit 3

https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

3/1/2024

CNE Financial Assisstance Eligibility Guidelines Summary of Sliding Scale Discounts and Maximum Patient Liability												
Income as % of Federal Poverty Level	100% and below	101%-200%	201%-210%	211%-220%	221%-230%	231%-240%	241%-250%	251%-260%	261%-270%	271%-280%	281%-290%	291%-300%
Sliding Scale Discount to the Patient	100%	100%	80%	60%	40%	20%	10%	10%	10%	5%	5%	5%
Maximum Annual Patient Liability See Incomes Below (multiply the income by max annual %)	0%	0%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%
Income for Family Size of 1	$15,060	$30,120	$31,626	$33,132	$34,638	$36,144	$37,650	$39,156	$40,662	$42,168	$43,674	$45,180
Income for Family Size of 2	$20,440	$40,880	$42,924	$44,968	$47,012	$49,056	$51,100	$53,144	$55,188	$57,232	$59,276	$61,320
Income for Family Size of 3	$25,820	$51,640	$54,222	$56,804	$59,386	$61,968	$64,550	$67,132	$69,714	$72,296	$74,878	$77,460
Income for Family Size of 4	$31,200	$62,400	$65,520	$68,640	$71,760	$74,880	$78,000	$81,120	$84,240	$87,360	$90,480	$93,600
Income for Family Size of 5	$36,580	$73,160	$76,818	$80,476	$84,134	$87,792	$91,450	$95,108	$98,766	$102,424	$106,082	$109,740
Income for Family Size of 6	$41,960	$83,920	$88,116	$92,312	$96,508	$100,704	$104,900	$109,096	$113,292	$117,488	$121,684	$125,880
Income for Family Size of 7	$47,340	$94,680	$99,414	$104,148	$108,882	$113,616	$118,350	$123,084	$127,818	$132,552	$137,286	$142,020
Income for Family Size of 8	$52,720	$105,440	$110,712	$115,984	$121,256	$126,528	$131,800	$137,072	$142,344	$147,616	$152,888	$158,160

For families with more than 8 persons, add $5,140 for each additional person
Asset protection threshold; individual $9,400; Family $14,100

Financial Assistance Policy

Exhibit 4

Amount Generally Billed (AGB)

In accordance with IRC §501(r)(5) CNE utilizes the Look-Back Method to calculate its AGB percentage. The AGB % is calculated annually and is based on all claims allowed by Medicaid, either alone or in combination with Medicare and all private health insurers over a 12-month period, divided by the gross charges associated with those claims. The applicable AGB % will be applied to gross charges to determine the AGB.

Any individual determined to be eligible for financial assistance under this FAP will not be chargedmore than AGB for any emergency or other medically necessary healthcare services. Any FAP- eligible individual will always be charged the lesser of AGB or any discount available under this policy.

Effective October 1, 2023, and October 1, 2024, respectively:

CNE Operating Unit	AGB	
	FY 2025	FY 2024
Butler Hospital	32%	28%
Kent County Memorial Hospital	29%	30%
Women and Infants Hospital	34%	33%

Financial Assistance Policy

Exhibit 5

The following documentation, if applicable, must accompany an application for Care New England Financial Assistance:

1. Tax return with supporting documentation for the most recent year filed.
2. Income Records* *(see detailed explanation below)*
3. Current pay stubs (minimum of 4 weeks)
4. Disability award letter
5. Social Security award letter (waived if direct deposit and bank statement is provided)
6. Parent's income (tax return) when person applying for financial assistant is a student
7. Asset Records** *(see detailed explanation below)*
8. Bank Statements including savings, checking, investment statements, annuities, CD's, money market accounts, stocks, bonds, pensions, and IRA's
9. Cash value of life insurance policies.
10. Personal property (other than primary residence and motor vehicle for personaluse)
11. Medical Assistance and/or HealthSource RI approval/denial
12. Copy of death certificate if applicable.
13. Proof of student status if applicable.
14. Letter of support if applicable.
15. Expenses and Liabilities
16. Most recent statement for mortgage/rent, property taxes, utilities, automobile payments/leases, credit cards, installment loans, auto/home insurance, medical expenses, andother expenses.

*Income Records: Income means the actual or estimated total annual cash receipts before taxes from salaries, wages, self-employment income, childcare income, rental income, unemployment compensation,temporary disability insurance, child support, alimony, worker's compensation, veteran's benefits, socialsecurity payments, dividend and interest income, royalties, private and public pensions, and public assistance. Also included in income are strike benefits, net lottery and gambling winnings and one-time insurance payments or injury compensation received in the calendar year in which the financial aid is sought for the hospital services.

**Asset Records: Assets means cash, cash-equivalent and other hard assets that can be converted into cash, including cash on hand, savings accounts, checking accounts, Certificates of Deposits (CDs), moneymarket accounts, stocks (common and preferred), bonds, mutual funds, IRAs, 401(k) s, 403(b) s, 457s, cash-in value of life insurance policies, personal property, motor vehicles other than for personal use, second homes and rental properties. Excluded from assets are primary resident and motor vehicle for personal use.