Financial Assistance Policy

Exhibit 1

Participating Providers	Non-Participating Providers
Edward Akelman MD	Peter Bellafiore MD
Karim Khanbhai MD	John Concannon MD
Nephrology Associates Inc	Northeast Institute of Plastic Surgery
Patricia Rompf MD	University Otalarynologuy

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 ❒ 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 ❒ 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

CNE FINANCIAL ASSISTANCE PROGRAM
2023 FINANCIAL ELIGIBILITY GUIDELINES

Effective 3/1/2023

Percent of Poverty Level:		200%	210%	220%	230%	240%	250%	260%	270%	280%	290%	300%
Family Size	**FPG**											
2023 Patient liability		0%	20%	40%	60%	80%	90%	90%	90%	95%	95%	95%
1	**14,580**	29,160	30,618	32,076	33,534	34,992	36,450	37,908	39,366	40,824	42,282	43,740
Max Liability Per Year			3,062	3,208	3,353	3,499	3,645	3,791	3,937	4,082	4,228	4,374
2	**19,720**	39,440	41,412	43,384	45,356	47,328	49,300	51,272	53,244	55,216	57,188	59,160
Max Liability Per Year			4,141	4,338	4,536	4,733	4,930	5,127	5,324	5,522	5,719	5,916
3	**24,860**	49,720	52,206	54,692	57,178	59,664	62,150	64,636	67,122	69,608	72,094	74,580
Max Liability Per Year			5,221	5,469	5,718	5,966	6,215	6,464	6,712	6,961	7,209	7,458
4	**30,000**	60,000	63,000	66,000	69,000	72,000	75,000	78,000	81,000	84,000	87,000	90,000
Max Liability Per Year			6,300	6,600	6,900	7,200	7,500	7,800	8,100	8,400	8,700	9,000
5	**35,140**	70,280	73,794	77,308	80,822	84,336	87,850	91,364	94,878	98,392	101,906	105,420
Max Liability Per Year			7,379	7,731	8,082	8,434	8,785	9,136	9,488	9,839	10,191	10,542
6	**40,280**	80,560	84,588	88,616	92,644	96,672	100,700	104,728	108,756	112,784	116,812	120,840
Max Liability Per Year			8,459	8,862	9,264	9,667	10,070	10,473	10,876	11,278	11,681	12,084
7	**45,420**	90,840	95,382	99,924	104,466	109,008	113,550	118,092	122,634	127,176	131,718	136,260
Max Liability Per Year			9,538	9,992	10,447	10,901	11,355	11,809	12,263	12,718	13,172	13,626
8	**50,560**	101,120	106,176	111,232	116,288	121,344	126,400	131,456	136,512	141,568	146,624	151,680
Max Liability Per Year			10,618		11,629	12,134	12,640	13,146	13,651	14,157	14,662	15,168

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

AGB
FY 23 Butler 31% Kent 28% WIH 35%
FY 22 Butler 30% Kent 31% WIH 34%
FY 21 Butler 46%, Kent 31%, WIH 34%
FY 20 Butler 47%, Kent 31%, WIH 35%

RI Medicaid GL $ 18,075

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 Medicare Fee-for-Service + 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 charged more 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, 2022, and October 1, 2021 respectively:

	2022	2021
Butler Hospital	31%	30%
Kent County Memorial Hospital	28%	31%
Women and Infants Hospital	35%	34%

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 isprovided)
6. Parent's income (tax return) when person applying for financial assistant is astudent
7. Asset Records*** (see detailed explanation below)*
    a. Bank Statements including savings, checking, investment statements, annuities, CD's, money market accounts, stocks, bonds, pensions and IRA's
    b. Cash value of life insurance policies.
    c. Personal property (other than primary residence and motor vehicle for personaluse)
8. Medical Assistance and/or HealthSource RI approval/denial
9. Copy of death certificate if applicable.
10. Proof of student status if applicable.
11. Letter of support if applicable.
12. Expenses and Liabilities
13. 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, social security 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), money market 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.