



# FINANCIAL ASSISTANCE POLICY

## Exhibit 2

### REQUIREMENTS FOR FINANCIAL ASSISTANCE PROGRAM – UNINSURED

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*)
  - a) current pay stubs (minimum of 4 weeks)
  - b) Disability award letter
  - c) Social Security award letter (waived if direct deposit and bank statement is provided)
  - d) Parent's income (tax return) when person applying for financial assistant is a student
- 3) Asset Records\*\* (*see detailed explanation below*)
  - a) Bank Statements including savings, checking, investment statements, annuities, CD's, money market accounts, stocks, bonds, pensions and IRAs
  - b) Cash value of life insurance policies.
  - c) Personal property (other than primary residence and motor vehicle for personal use)
- 4) Medical Assistance and/or HealthSource RI approval/denial
- 5) Copy of death certificate if applicable.
- 6) Proof of student status if applicable.
- 7) Letter of support if applicable.

**\*Income Records:** Income means the actual or estimated total annual cash receipts before taxes from salaries, wages, self-employment income, child care 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.

## APPLICATION FOR HOSPITAL FINANCIAL AID

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

Hospital: <input type="checkbox"/> Butler <input type="checkbox"/> Kent <input type="checkbox"/> Memorial <input type="checkbox"/> 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: <input type="checkbox"/> English <input type="checkbox"/> Non-English		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> No Ethnicity Identified		
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander		
<input type="checkbox"/> White <input type="checkbox"/> Other or Multiple Races <input type="checkbox"/> 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:	<b>TOTAL:</b>		
Other:			
<b>MONTHLY INCOME:</b>			
<b>ANNUAL INCOME:</b>			

"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: \_\_\_\_\_

## REQUIREMENTS FOR FINANCIAL ASSISTANCE PROGRAM – UNDERINSURED

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*)
  - a. Current pay stubs (minimum of 4 weeks)
  - b. Disability award letter
  - c. Social Security award letter (waived if direct deposit and bank statement is provided)
  - d. Parent's income (tax return) when person applying for financial assistant is a student
- 3 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 personal use)
- 4 Medical Assistance and/or HealthSource RI approval/denial
- 5 Copy of death certificate if applicable.
- 6 Proof of student status if applicable.
- 7 Letter of support if applicable.
- 8 Expenses and Liabilities
- 9 Most recent statement for mortgage/rent, property taxes, utilities, automobile payments/leases, credit cards, installment loans, auto/home insurance, medical expenses and other expenses.

**\*Income Records:** Income means the actual or estimated total annual cash receipts before taxes from salaries, wages, self-employment income, child care 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.

## APPLICATION FOR HOSPITAL FINANCIAL AID-UNDERINSURED

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

Hospital: <input type="checkbox"/> Butler <input type="checkbox"/> Kent <input type="checkbox"/> Memorial <input type="checkbox"/> 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	
<b>MONTHLY INCOME:</b>					
<b>ANNUAL INCOME:</b>			<b>TOTAL:</b>		<b>TOTAL:</b>

"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: \_\_\_\_\_

**CNE FINANCIAL ASSISTANCE PROGRAM  
2019 FINANCIAL ELIGIBILITY GUIDELINES**

Effective 3/1/2019												
Percent of Poverty Level:		200%	210%	220%	230%	240%	250%	260%	270%	280%	290%	300%
Family Size	FPG											
2019 Patient liability		0%	20%	40%	60%	80%	90%	90%	90%	95%	95%	95%
<b>1</b>	<b>14,052</b>	28,104	29,509	30,914	32,320	33,725	35,130	36,535	37,940	39,346	40,751	42,156
Max Liability Per Year			2,951	3,091	3,232	3,372	3,513	3,654	3,794	3,935	4,075	4,216
<b>2</b>	<b>19,024</b>	38,048	39,950	41,853	43,755	45,658	47,560	49,462	51,365	53,267	55,170	57,072
Max Liability Per Year			3,995	4,185	4,376	4,566	4,756	4,946	5,136	5,327	5,517	5,707
<b>3</b>	<b>23,997</b>	47,994	50,394	52,793	55,193	57,593	59,993	62,392	64,792	67,192	69,591	71,991
Max Liability Per Year			5,039	5,279	5,519	5,759	5,999	6,239	6,479	6,719	6,959	7,199
<b>4</b>	<b>28,969</b>	57,938	60,835	63,732	66,629	69,526	72,423	75,319	78,216	81,113	84,010	86,907
Max Liability Per Year			6,083	6,373	6,663	6,953	7,242	7,532	7,822	8,111	8,401	8,691
<b>5</b>	<b>33,942</b>	67,884	71,278	74,672	78,067	81,461	84,855	88,249	91,643	95,038	98,432	101,826
Max Liability Per Year			7,128	7,467	7,807	8,146	8,486	8,825	9,164	9,504	9,843	10,183
<b>6</b>	<b>38,914</b>	77,828	81,719	85,611	89,502	93,394	97,285	101,176	105,068	108,959	112,851	116,742
Max Liability Per Year			8,172	8,561	8,950	9,339	9,729	10,118	10,507	10,896	11,285	11,674
<b>7</b>	<b>43,887</b>	87,774	92,163	96,551	100,940	105,329	109,718	114,106	118,495	122,884	127,272	131,661
Max Liability Per Year			9,216	9,655	10,094	10,533	10,972	11,411	11,849	12,288	12,727	13,166
<b>8</b>	<b>48,859</b>	97,718	102,604	107,490	112,376	117,262	122,148	127,033	131,919	136,805	141,691	146,577
Max Liability Per Year			10,260	10,749	11,238	11,726	12,215	12,703	13,192	13,681	14,169	14,658
*For families with more than 8 persons, add \$4,973 for each additional person.												
*Asset protection threshold; Individual \$10,300, Family \$15,500												

**CNE FINANCIAL ASSISTANCE PROGRAM  
2020 FINANCIAL ELIGIBILITY GUIDELINES**

Effective 3/1/2020												
Percent of Poverty Level:		200%	210%	220%	230%	240%	250%	260%	270%	280%	290%	300%
Family Size	FPG											
2020 Patient liability		0%	20%	40%	60%	80%	90%	90%	90%	95%	95%	95%
<b>1</b>	<b>12,760</b>	25,520	26,796	28,072	29,348	30,624	31,900	33,176	34,452	35,728	37,004	38,280
Max Liability Per Year			2,680	2,807	2,935	3,062	3,190	3,318	3,445	3,573	3,700	3,828
<b>2</b>	<b>17,240</b>	34,480	36,204	37,928	39,652	41,376	43,100	44,824	46,548	48,272	49,996	51,720
Max Liability Per Year			3,620	3,793	3,965	4,138	4,310	4,482	4,655	4,827	5,000	5,172
<b>3</b>	<b>21,720</b>	43,440	45,612	47,784	49,956	52,128	54,300	56,472	58,644	60,816	62,988	65,160
Max Liability Per Year			4,561	4,778	4,996	5,213	5,430	5,647	5,864	6,082	6,299	6,516
<b>4</b>	<b>26,200</b>	52,400	55,020	57,640	60,260	62,880	65,500	68,120	70,740	73,360	75,980	78,600
Max Liability Per Year			5,502	5,764	6,026	6,288	6,550	6,812	7,074	7,336	7,598	7,860
<b>5</b>	<b>30,680</b>	61,360	64,428	67,496	70,564	73,632	76,700	79,768	82,836	85,904	88,972	92,040
Max Liability Per Year			6,443	6,750	7,056	7,363	7,670	7,977	8,284	8,590	8,897	9,204
<b>6</b>	<b>35,160</b>	70,320	73,836	77,352	80,868	84,384	87,900	91,416	94,932	98,448	101,964	105,480
Max Liability Per Year			7,384	7,735	8,087	8,438	8,790	9,142	9,493	9,845	10,196	10,548
<b>7</b>	<b>39,640</b>	79,280	83,244	87,208	91,172	95,136	99,100	103,064	107,028	110,992	114,956	118,920
Max Liability Per Year			8,324	8,721	9,117	9,514	9,910	10,306	10,703	11,099	11,496	11,892
<b>8</b>	<b>44,120</b>	88,240	92,652	97,064	101,476	105,888	110,300	114,712	119,124	123,536	127,948	132,360
Max Liability Per Year			9,265	9,706	10,148	10,589	11,030	11,471	11,912	12,354	12,795	13,236
*For families with more than 8 persons, add \$4,480 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 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, 2020:**

Butler Hospital 46%

Kent County Memorial Hospital 31%

Women and Infants Hospital 34%

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