# Financial Assistance Policy

**Exhibit 1**

| Participating Providers | Non-Participating Providers |
|---|---|
| Anjulika Chawla MD | Calenda Eye Care |
| Bradley D. Denardo MD | A. Michael Coppa MD |
| David A. Lowe MD | Arnold-Peter C. Weiss MD |
| Karim Z. Khanbhai MD | Colleen C. Vitale MD |
| Marvin S. Wasser MD | Cynthia M. Hanna MD |
| Rachel A. Altura MD | Daniel F. Lukowicz MD |
| Thomas M. Renaud MD | Jason B. Boudjouk MD |
| Umberto Capuano MD | Jerome M. Larkin MD |
| Brain & Spine Neurosurgical Institute | John E. Concannon DO |
| Narragansett Foot and Ankle, Inc | John E. Duhaime DMD |
| Nicklas B.E. Oldenburg MD | Leland S. Blough DMD |
| Providence Community Health Centers | Leonard A. Mermel DO |
| RI Medical Imaging | Pierre R. Michaud MD |
| Richard San Antonio | Seth Feder MD |
| Roseanne M. Lowe PHD | Stephen L. Matarese DO |
| Smithfield Pediatrics | Associates in Primary Care |
| Wood River Health Service | Bayside OBGYN INC |
| XRA Medical Imaging | Blackstone Valley Pediatrics |
| | Center for OB-GYN |
| | Centerville Podiatry |
| | East Bay Neurology |
| | East Bay Pediatrics |
| | East Greenwich Family Practice |
| | East Greenwich Ophthalmology |
| | Fredy Roland MD Inc |
| | Hematology and Oncology Associates |
| | Koch Eye Associates |
| | Partners in OB/GYN |
| | Peter Bellafiore |
| | Santiago Medical Group |
| | The Medical Group of RI |
| | Tollgate OB/GYN |
| | Waterman Pediatrics |
| | West Bay Orthopedics |

# 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: ❒ 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 | 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: _____

**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: ❒ 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/Africian 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: _____

# CNE FINANCIAL ASSISTANCE PROGRAM
## 2018 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** | | | | | | | | | | | |
| **2018 Patient liability** | | **0%** | **20%** | **40%** | **60%** | **80%** | **90%** | **90%** | **90%** | **95%** | **95%** | **95%** |
| **1** | **14,052** | 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 |
| **2** | **19,024** | 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 |
| **3** | **23,997** | 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 |
| **4** | **28,969** | 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 |
| **5** | **33,942** | 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 |
| **6** | **38,914** | 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 |
| **7** | **43,887** | 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 |
| **8** | **48,859** | 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 $10,000, Family $15,000

# 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%** |
| **1** | **14,052** | 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 |
| **2** | **19,024** | 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 |
| **3** | **23,997** | 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 |
| **4** | **28,969** | 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 |
| **5** | **33,942** | 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 |
| **6** | **38,914** | 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 |
| **7** | **43,887** | 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 |
| **8** | **48,859** | 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

**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, 2019:**

Butler Hospital 47%

Kent County Memorial Hospital 33%

Women and Infants Hospital 37%

Care New England