| `Texas Nonprofit Hospitals* |
| Part II Summary of Current Hospital Charity Care Policy and |
| Community Benefits for Inclusion in DSHS Charity Care Manual as Required |
| by Texas Health and Safety Code, § 311.0461** |
| 2022 |

Facility Identification (FID): 1356566 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: ContinueCare Hospital at Medical Center Odessa **County:** ECTOR

Mailing Address:

Physical Address if different from above:

Effective Date of the current policy:

Date of Scheduled Revision of this policy:

How often do you revise your charity care policy?

Provide the following information on the office and contact person(s) processing requests for charity care.

Name of the office/department:

Mailing Address:

Contact Person: Title:

Phone: Fax:

Person completing this form if different from above:

Name: Phone:

* This summary form is to be completed by each **nonprofit** hospital. Hospitals in a system must report on an individual hospital basis. Public hospitals, for-profit hospitals participating in the Medicaid disproportionate share hospital program and exempt hospitals are not required to complete this form. This form is only available in PDF format at DSHS web site: www.dshs.texas.gov/chs/hosp under 2022 Annual Statement of Community Benefits Standard.

** The information in the manual will be made available for public use. Please report most current information on the charity care policy and community benefits provided by the hospital.

*** The list is also available on DSHS web site: http://www.dshs.texas.gov/chs/hosp/

I. Charity Care Policy:

1. Include your hospital's Charity Care Mission statement in the space below.

2. Provide the following information regarding your hospital's current charity care policy.

    a. Provide definition of the term **charity care** for your hospital.

    Medical services rendered to those who qualify

    b. What percentage of the federal poverty guidelines is financial eligibility based upon? Check one.
    4

1. 100%	☑	4. <200%
2. <133%		5. Other, specify _____
3. <150%		

    c. Is eligibility based upon net or ☑ gross income? Check one.

    d. Does your hospital have a charity care policy for the Medically Indigent?

☑ YES NO   IF yes, provide the definition of the term **Medically Indigent**.

means a patient whose medical or hospital blls from all unrelated providers, after payment by all their parties, exceed 10% of such patient's yearly household income is greater than 200% but less than or equal to 400% of the GPG and who is unable to pay the outstanding patient account balance

    e. Does your hospital use an Assets test to determine eligibility for charity care?

 YES ☑ NO   If yes, please briefly summarize method.

    f. Whose income and resources are considered for income and/or assets eligibility determination?

                          1. Single parent and children

                          2. Mother, Father and Children

                          3. All family members

☑   4. All household members

                          5. Other, please explain _____

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g. What is included in your definition of income from the list below? Check all that apply.

☑ 1. Wages and salaries before deductions

☑ 2. Self-employment income

☑ 3. Social security benefits

☑ 4. Pensions and retirement benefits

☑ 5. Unemployment compensation

   6. Strike benefits from union funds

☑ 7. Worker's compensation

   8. Veteran's payments

   9. Public assistance payments

   10. Training stipends

   11. Alimony

   12. Child support

   13. Military family allotments

   14. Income from dividends, interest, rents, royalties

☑ 15. Regular insurance or annuity payments

   16. Income from estates and trusts

   17. Support from an absent family member or someone not living in the household

   18. Lottery winnings

   19. Other, specify _____

3. Does application for charity care require completion of a form? ☑ YES   NO

   If YES,

   a. **Please attach a copy of the charity care application form.**

   b. How does a patient request an application form? Check all that apply.

☑ 1. By telephone

☑ 2. In person

   3. Other, please specify _____

   c. Are charity care application forms available in places other than the hospital?

☑ YES   NO   If, YES, please provide name and address of the place.

website:continuecare.org/odessa/about us,

   d. Is the application form available in language(s) other than English?

      ☑ YES   NO

      If yes, please check

      Spanish ☑ 1 Other, please specify _____

4. When evaluating a charity care application,

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a. How is the information verified by the hospital?

        1. The hospital independently verifies information with third party evidence (W2, pay stubs)

        2. The hospital uses patient self-declaration

☑   3. The hospital uses independent verification and patient self-declaration

b. What documents does your hospital use/require to verify income, expenses, and assets? Check all that apply.

☑   1. W2-form

        2. Wage and earning statement

        3. Paycheck remittance

☑   4. Worker's compensation

☑   5. Unemployment compensation determination letters

☑   6. Income tax returns

        7. Statement from employer

☑   8. Social security statement of earnings

☑   9. Bank statements

        10. Copy of checks

        11. Living expenses

        12. Long term notes

        13. Copy of bills

        14. Mortgage statements

        15. Document of assets

        16. Documents of sources of income

        17. Telephone verification of gross income with the employer

        18. Proof of participation in gov't assistance programs such as Medicaid

        19. Signed affidavit or attestation by patient

        20. Veterans benefit statement

        21. Other, please specify _____

5. When is a patient determined to be a charity care patient? Check all that apply.

        ☑   a. At the time of admission

        ☑   b. During hospital stay

        ☑   c. At discharge

                 d. After discharge

                 e. Other, please specify _____

6. How much of the bill will your hospital cover under the charity care policy?

                 a. 100%

        ☑   b. A specified amount/percentage based on the patient's financial situation

                 c. A minimum or maximum dollar or percentage amount established by the hospital

                 d. Other, please specify _____

7. Is there a charge for processing an application/request for charity care assistance?

     YES ☑ NO

8. How many days does it take for your hospital to complete the eligibility determination process? up to 30

9. How long does the eligibility last before the patient will need to reapply? Check one.

                 a. Per admission

        ☑   b. Less than six months

                 c. One year

                 d. Other, specify _____

10. How does the hospital notify the patient about their eligibility for charity care? Check all that apply. Check all that apply?

        ☑   a. In person

        ☑   b. By telephone

        ☑   c. By correspondence

                 d. Other, specify _____

11. Are all services provided by your hospital available to charity care patients?

     YES ☑NO

If NO, please list services not covered for charity care patients (e.g. transplant services, ER services, other outpatient services, physician's fees).

12. Does your hospital pay for charity care services provided at hospitals owned by others?

     ☑ YES   NO

II. Community Benefits Projects/Activities:
Provide information on name, brief description (3 lines), target population or purpose (3 lines) for each of the community benefits projects/activities CURRENTLY being undertaken by your hospital (example: diabetes awareness).
Health Fairs, Clinical education, resources

Additional Information:
Use this space if more space is required for comments or to elaborate on any of the information supplied on this form. Please refer to the response by question and item number.

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NOTE: This is the twenty-first year the charity care and community benefits form is being used for collecting the information required under Texas Health and Safety Code, § 311.0461. If you have any suggestions or questions, please include them in the space below or contact Dwayne Collins, Center for Health Statistics, Texas Department of State Health Services at (512)776-7261 or fax:(512)776-7344 or E-mail: dwayne.collins@dshs.texas.gov.

Name of Hospital: _____ City: _____

Contact Name: _____ Phone: _____

Suggestions/questions: