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**
-2011-

Facility Identification (FID): 1615092 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: EAST TEXAS MEDICAL CENTER TYLER **County:** SMITH

Mailing Address: PO BOX 6400 TYLER, TX 75711

Physical Address if different from above: 1000 S BECKHAM TYLER, TX 75701

Effective Date of the current policy: 11/1/2009

Date of Scheduled Revision of this policy: 2/1/2012

How often do you revise your charity care policy? ANNUALLY

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

Name of the office/department: BUSINESS OFFICE

Mailing Address: PO BOX 7000 TYLER, TX 75711

Contact Person: MARGARET ASHMORE Title: MANAGER, COMMUNITY BENEFITS

Phone: (903) 535-6012 Fax: (903) 596-3807 E-Mail MAASHMORE@ETMC.ORG

Person completing this form if different from above:

Name: BELL JACKSON Phone: (903) 531-8121

* 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 also available in Word or PDF formats at DSHS web site: www.dshs.state.tx.us/chs/hosp under 2010 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: www.dshs.state.tx.us/chs/hosp/.

I. Charity Care Policy:

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

BY VIRTUE OF OUR EXEMPTION FROM FEDERAL AND STATE TAXES AND AS A PART OF OUR MISSION TO SERVE THE HEALTH CARE NEEDS OF OUR COMMUNITY, ETMC WILL PROVIDE CHARITY CARE TO PATIENTS WHO MEET THE CRITERIA OF OUR POLICY AND DO NOT HAVE THE FINANCIAL MEANS TO PAY FOR HOSPITAL SERVICES.

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

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

IN AND OUT PATIENT MEDICAL TREATMENT AND DIAGNOSTIC SERVICES FOR UNINSURED OR UNDERINSURED PATIENTS WHO CANNOT AFFORD TO PAY FOR THE CARE ACCORDING TO THE GUIDELINES OF OUR POLICY.

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

☐ 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**.

A PATIENT WHOSE UNPAID HOSPITAL CHARGES EXCEED THEIR ABILITY TO PAY AND WHOSE REMAINING BILL WILL RESULT IN NO OBLIGATION OR A DISCOUNTED OBLIGATION TO PAY FOR THE SERVICES RENDERED, BASED ON THE ELIGIBILITY CRITERIA SET FORTH IN OUR POLICY.

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 ALL ADULTS LEGALLY FINANCIALLY RESPONSIBLE

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 MAIL, ETMC WEBSITE

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.

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

☑ YES ☐ NO

If yes, please check

☑ Spanish ☐ Other, specify _____

4. When evaluating a charity care application,

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. Pay check 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 govt 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?
30 DAYS FROM RESOLUTION OF ALL THIRD PARTY INSURANCE AND/OR FUNDING ELIGIBILITY EFFORTS

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 6 MONTHS

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

☑ a. In person

☑ b. By telephone

☑ c. By correspondence

☑ d. Other, specify ELIMINATE BILLING FOR PATIENTS RECEIVING 100% CHARITY ASSISTANCE. FOR PATIENTS RECEIVING PARTIAL ASSISTANCE A BILLING STATEMENT REFLECTING THE BALANCE AFTER CHARITY IS SENT TO THE CUSTOMER

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).

COSMETIC PROCEDURES,OUTPATIENT CHEMO THERAPY, CRNA SERVICES, OTHER SCHEDULED ELECTIVE SERVICES

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).

1.EMERGENCY CARE- MAINTAIN MEDICAL STAFF COMPOSITION AND CALL COVERAGE NECESSARY TO SUSTAIN TRAUMA CENTERS - ALL SERVICE AREA POPULATION. 2.CARDIAC CARE - REDUCE MORTALITY RATES AND IMPROVE OUTCOMES FOR PATIENTS WITH CARDIOVASCULAR DISEASE - PERSONS WITH CARDIAC DISEASE 3.NEUROLOGICAL CARE - MAINTAIN TDSHS STROKE CENTER ACCREDITATION AND IMPROVE COMMUNITY AWARENESS OF THE SIGNS AND SYMPTOMS OF STROKE - PERSONS WHO MAY HAVE A STROKE 4.CANCER CARE - INCREASE THE NUMBER OF SCREENINGS FOR BREAST AND COLORECTAL CANCERS - ALL ADULTS WITHIN SERVICE AREA 5.KIDNEY TRANSPLANTATION - SUPPORT ORGAN DONATION EDUCATION AND MAINTAIN KIDNEY TRANSPLANT PROGRAM - POTENTIAL ORGAN DONORS AND DONOR RECEPIENTS 6.MENTAL HEALTHCARE - EXPAND PLACEMENT OF MASTERS TRAINED MENTAL HEALTH COUNSELORS AND SERVICE AS RESOURCE FOR MENTAL HEALTH SERVICES - PERSONS WITH MENTAL HEALTH ILLNESS 7.ACCESS TO CARE - INCREASE PRIMARY CARE PROVIDERS IN RURAL COMMUNITIES - RURAL POPULATIONS

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.

REGARDING QUESTION 3:3. DOES APPLICATION FOR CHARITY CARE REQUIRE COMPLETION OF A FORM? ETMC DOES REQUIRE AN APPLICATION EXCEPT INSTANCES WHERE THE CHARITY DETERMINATION IS BASED ON A NON-COVERED SERVICE OF A GOVERNMENT SPONSORED PROGRAM, WHERE INCOME ELEGIBILITY FOR THAT PROGRAM IS LESS THAN 200% OF THE FEDERAL POVERTY GUILDELINE. REGARDING QUESTION 4.B:4.B WHAT DOCUMENTS DOES YOUR HOSPITAL USE/REQUIRE TO VERIFY INCOME, EXPENSES, AND ASSETS? CHECK ALL THAT APPLY. THE ANSWER STATED IS BASED ON THE QUESTION PHRASE "USE/REQUIRE' TO MEAN "USE AND/OR REQUIRE"