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): 3750063	(Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Baptist St. Anthony's Hospital **County:** Potter

Mailing Address: 1600 Wallace Blvd; Amarillo, TX 79106

Physical Address if different from above: _____

Effective Date of the current policy: 4/16/2010

Date of Scheduled Revision of this policy: 12/31/2012

How often do you revise your charity care policy? Periodically

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

Name of the office/department: BSA Business Office

Mailing Address: P.O. Box 950

Contact Person: Tawnya Cooper Title: Business Office Manager

Phone: (806) 212-7823 Fax: (806) 212-6956 E-Mail tawnya.cooper@bsahs.org

Person completing this form if different from above:

Name: Brian Schrayer Phone: (806) 212-6719

* 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.

In keeping with the mission and philosophy of the Baptist St. Anthony's Health System (BSA), BSA will provide charity care services, within the resources available, to financially and medically indigent patients.

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

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

Unreimbursed costs of services provided to the financially and medically indigent.

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**.

Those patients who may not normally qualify for financial aid but due to a situation resulting in catastrophic medical expenses (25% or more of their annual income) may need some financial asistance.

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

☑ YES ☐ NO If yes, please briefly summarize method.

Assets are evaluated to determine if the guarantor has any liquid assets in excess of those critical to living or not being used to support the family's support system.

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 _____

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 e-mail

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.

Amarillo Surgical Group
#6 Medical Drive, Amarillo, TX 79106

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 Other documentation that might be appropriate for a patient's unique situation

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 During collection process

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?
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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 for Non-Medicare Beneeficiaries; 12 months for Medicare Beneficiaries

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 _____

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).

Non-medically necessary procedures, cosmetic procedures, and bariatric 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).

See attached file: Annual Report Community Benefits 2011.

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.