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): 4251683	(Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Glen Rose Medical Center **County:** Somervell

Mailing Address: PO Box 2099, Glen Rose, Texas 76043

Physical Address if different from above: 1021 Holden Street, Glen Rose, Texas 76043

Effective Date of the current policy: 10/1/2010

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

How often do you revise your charity care policy? Every 2 - 3 years

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 2099, Glen Rose, Texas 76043

Contact Person: Meghan Simpson Title: Charity

Phone: (254) 897-2215 Fax: (254) 897-1446 E-Mail mbiggs@grmf.org

Person completing this form if different from above:

Name: Kristina Heffernan Phone: (254) 897-2215

* 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.

N/A

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

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

We use the Federal Poverty Guidelines

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

☐ 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**.

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

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

Applicants must provide W2 statements or Federal Income Tax returns as well as paycheck stubs and copies of bills

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 _____

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 Application reviewed by charity committee

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 Application reviewed by charity committee

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

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?

- ☑ 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).

Annual health fairs, drive by flu shots, offer onsite wellness program and community prostate screening.

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.