

**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\*\***

<b>Facility Identification (FID):</b>	4373555	(Enter 7-digit FID# from attached hospital listing)***
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**Name of Hospital:** Swisher Memorial Hospital **County:** Swisher

**Mailing Address:** P.O. Box 808, Tulia, TX 79088

**Physical Address if different from above:** 539 SE 2nd Street, Tulia, TX 79088

**Effective Date of the current policy:** 01/13/2014

**Date of Scheduled Revision of this policy:** 01/14/2014

**How often do you revise your charity care policy?** At least annually

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

Name of the office/department: Patient Assistance

Mailing Address: P.O. Box 808

Contact Person: Angie Davis Title: Patient Advocate

Phone: (806) 995-8298 Fax: (806) 995-8283 E-Mail: adavis@swisherhospital.com

Person completing this form if different from above:

Name : Jerry Pickett Phone : (806) 995-8268

\* 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.state.tx.us/chs/hosp](http://www.dshs.state.tx.us/chs/hosp) under 2013 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/](http://www.dshs.state.tx.us/chs/hosp/).

## I. Charity Care Policy:

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

To better serve the health care needs of our community, Swisher Memorial Healthcare System will provide charity care to patients without financial means to pay for hospital services. Charity care will be provided to all patients who present themselves for care at Swisher Memorial Healthcare System without regard to race, creed, color, or national origin and who are classified as financially indigent or medically indigent according to the hospital's eligibility system.

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

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

1. Financially Indigent: a. A financially indigent patient is a person who is uninsured and is accepted for care with no obligation or discounted obligation to pay for services rendered based on Swisher Memorial Healthcare System's eligibility criteria set forth in this policy. b. To be eligible for charity care as a financially indigent patient, a person's total household income shall be at or below 150% of the current federal poverty guidelines (attached). Swisher Memorial Healthcare System may consider other financial assets and liabilities for the person when determining eligibility. c. Swisher Memorial Healthcare System will use the most current poverty income guidelines issued by the U.S. Department of Health and Human Services to determine an individual's eligibility for charity care as a financially indigent patient. The poverty income guidelines are published in the Federal Register in February of each year and for the purposes of this policy will become effective the first day of the month following the month of publication. d. In no event will Swisher Memorial Healthcare System establish eligibility criteria for financially indigent patients which sets the income level for charity care lower than the required for counties under the State Indigent Health Care and Treatment Act, or higher than 200% of the current federal poverty income guidelines. Swisher Memorial Healthcare System may, however, adjust the eligibility criteria from time to time based on the financial resources of Swisher Memorial Healthcare System and as necessary to meet the charity care needs of the community. 2. Medically Indigent: a. A medically indigent patient is a person whose medical bills after payment by third party payers exceed a specified percentage of the person's annual gross income as set forth in this policy and who is unable to pay the remaining bill. Long-term, catastrophic illness, and the effects thereof may be considered along with the current term of service when determining this percentage. b. A determination of the patient's ability to pay the remainder of the bill will be based on whether the patient reasonably can be expected to pay the account in full over a 3-year period. c. Any determination that a patient has the ability to pay the remainder of a bill does not prevent a reassessment of the patient's ability to pay at a later date

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

Check one.

- |          |                                     |                         |
|----------|-------------------------------------|-------------------------|
| 1. <100% | <input checked="" type="checkbox"/> | 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**.

2. Medically Indigent: a. A medically indigent patient is a person whose medical bills after payment by third party payers exceed a specified percentage of the person's annual gross income as set forth in this policy and who is unable to pay the remaining bill. Long-term, catastrophic illness, and the effects thereof may be considered along with the current term of service when determining this percentage. b. A determination of the patient's ability to pay the remainder of the bill will be based on whether the patient reasonably can be expected to pay the account in full over a 3-year period. c. Any determination that a patient has the ability to pay the remainder of a bill does not prevent a reassessment of the patient's ability to pay at a later date

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 \_\_\_\_\_

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
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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, please specify

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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? 14

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).

SMHS is active in the community by providing Flu & Pneumonia shots to seniors, home health patients and nursing home residents. We also provide drug screening and sports physicals to District students and medical services to students at Waylon University in Plainview, TX. In 2014, SMHS implemented a nurse call line to help Medicaid and uninsured patients make better decisions regarding emergency department use.

### **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 twelfth 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.state.tx.us](mailto:dwayne.collins@dshs.state.tx.us).

Name of Hospital: \_\_\_\_\_ City: \_\_\_\_\_  
Phone \_\_\_\_\_  
Contact Name: \_\_\_\_\_ : \_\_\_\_\_

**Suggestions/questions:**