

**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\*\***

-2014-

<b>Facility Identification (FID):</b> 2093151 (Enter 7-digit FID# from attached hospital listing)***
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**Name of Hospital:** Central Texas Medical Center **County:** HAYS

**Mailing Address:** 1301 Wonder World Drive, San Marcos TX 78666

**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: \_\_\_\_\_ E-Mail Allen.Weber@ahss.org

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.state.tx.us/chs/hosp](http://www.dshs.state.tx.us/chs/hosp) under 2014 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.

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

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

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**.

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 \_\_\_\_\_

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 \_\_\_\_\_

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?
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).

Meeting the needs of our community is a tradition that goes back more than a quarter of a century at Central Texas Medical Center (CTMC) in San Marcos, Texas. Our heritage as part of Adventist Health System and our faith-based mission, vision and values demand no less of us as we endeavor to fulfill our mission of extending the healing ministry of Christ. Our goal is to be the Best Hospital in Central Texas and offer a complete array of services found at the best community hospitals in the nation. In achieving that goal we offer top quality health care, education and interactive programs to help all members of our community learn better ways to care for themselves and those they love. CTMC and its medical staff of more than 220 consulting physicians sponsor specialty clinics in San Marcos and surrounding communities including Kyle, Wimberley, Lockhart and New Braunfels. These clinics offer specialists in cardiology, gastroenterology, neurology, obstetrics and gynecology, oncology, ophthalmology, oral and maxillofacial surgery, orthopedics, podiatry and general surgery. Through our CREATION Health Institute, each year CTMC sponsors a variety of free or dramatically discounted health screenings, health fairs, educational seminars and other community events. Through our Mission Council and its outreach efforts, a variety of community social service agencies, non-profits and individuals in need receive volunteer labor and/or funding support from CTMC organizational and individual associate support. Through the CTMC Foundation Women's Council, area non-profits serving women and children are eligible to apply for annual impact grants. Additionally, annual planning process is conducted in all departments to review and set goals to make sure that the services provided are meeting the needs of our community. This information is compiled into an overall strategic plan for the organization. All existing policies and procedures are reviewed and revised as needed. A Community Benefits budget is developed each year which analyzes the amount of charity care, Medicaid revenue, government sponsored indigent care and education and community outreach programs are provided by CTMC. The Annual Budget is an outgrowth of the data sources identified in the below referenced Needs Assessment Sources

### **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: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Suggestions/questions:**