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-

Facility Identification (FID): 2652135 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Peterson Regional Medical Center **County:** Kerr

Mailing Address: 551 Hill Country Drive, Kerrville, Texas 78028

Physical Address if different from above: _____

Effective Date of the current policy: 05/15/2014

Date of Scheduled Revision of this policy: 05/15/2016

How often do you revise your charity care policy? Every two 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: 551 Hill Country Drive, Kerrville, TX 78028

Contact Person: Ashley Natus Title: Supervisor of Collections

Phone: (803) 258-7609 Fax: (830) 258-7678 E-Mail anatus@petersomrmc.com

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 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/.

I. Charity Care Policy:

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

To provide health care services to all individuals in our community without regard to their ability to pay.

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

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

Health care provided for free or at reduced prices to low income patients.

b. What percentage of the federal poverty guidelines is financial eligibility based upon? Check one.5

1. <100%
2. <133%
3. <150%
4. <200%
5. Other, specify <300%

☑

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 person whose medical bills, after payment by any third-party, exceeds fifty percent of the person's annual gross income and is unable to satisfy patient balances.

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 From the hospital's 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.

Peterson Regional Ambulatory Care Center and Peterson Community Care , 260 Cully Dr. and 823 Junction Hwy., Kerrville, TX 78028

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 Prior to services

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

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).

Any services that are considered elective and not medically necessary.

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.

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.

Name of Hospital: _____ City: _____

Contact Name: _____ Phone: _____

Suggestions/questions: