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**
2016

Facility Identification (FID): 1671605 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Shriners Hospital for Children- Galveston       County: Galveston
Mailing Address: 815 Market Street, Galveston, Texas 77550

Physical Address if different from above: ________________________________

Effective Date of the current policy: 01/18/2016 ________________________________

Date of Scheduled Revision of this policy: 01/18/2018 ________________________________

How often do you revise your charity care policy? every 2 years ________________________________

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

Name of the office/department: Revenue Cycle ________________________________
Mailing Address: 815 Market Street, Galveston, Texas 77550 ________________________________
Contact Person: Jessica Campos       Title: Revenue Cycle Liaison
Phone: (409) 770-6953    Fax: (409) 770-6729    E-Mail  jcampos@shrinenet.org ________________________________

Person completing this form if different from above:
Name: Brenda Rubio       Phone: (409) 770-6771 ________________________________
* 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.
Identify uninsured patients seeking services at its facilities and implement standards and requirements which identify and qualify patients for Charity Care.

2. Provide the following information regarding your hospital’s current charity care policy.
   a. Provide definition of the term charity care for your hospital.
      A type of financial assistance available to Shriners Hospitals for Children patients and their families when the family earns less than 400% of the United States Federal Poverty Level. Charity Care is an adjustment code eliminating amounts owed for patient

   b. What percentage of the federal poverty guidelines is financial eligibility based upon?
      Check one.
      1. <100%  
      2. <133%  ☑  
      3. <150%  
      4. <200%  
      5. Other, specify 400% 

   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.
      Patients requiring medical services with no insurance coverage or ability to pay.

   e. Does your hospital use an Assets test to determine eligibility for charity care?
      ☑YES  NO   If yes, please briefly summarize method.
Financial counselor conducts a means test with uninsured patients to determine FPI. Supporting documentation requested to verify income.

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?
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? 30 days

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).
    1671605

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).

We actually conducted a community assessment needs.

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: