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): 1792735 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Pampa Regional Medical Center
County: GRAY

Mailing Address: ONE MEDICAL PLAZA, PAMPA, TEXAS 79065

Physical Address if different from above: 3001 Perryton Parkway PAMPA, TEXAS 79065-2819

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

Date of Scheduled Revision of this policy: 03/01/2017

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.

PAMPA REGIONAL MEDICAL CENTER/ BUSINESS OFFICE

Mailing Address: ONE MEDICAL PLAZA PAMPA, TEXAS 79065

Contact Person: KACI TAYLOR
Title: Collector
Phone: (806) 663-5504 Fax: (806) 663-5655 E-Mail: ktaylor@primehealthcare.com

Person completing this form if different from above:
Name: Eric Kingcade
Phone: (806) 663-5746
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.

The Hospital will offer a charity care program for those patients who meet the eligibility tests described below and comply with the requirements of Health & Safety Code sections 127400 to 127446.

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. Self-Pay Patients - A patient qualifies for the Charity Care Program if all of the following conditions are met: (1) the patient does not have third party coverage from a health insurer, health care service plan, union trust plan, Medicare, or Medi-Cal

   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 350

   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

3. Are charity care application forms available in places other than the hospital?

   YES ☑ NO  If, YES, please provide name and address of the place.

4. 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? up to 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 6 months __________________________

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).
    1792735

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).

Patients who lack insurance or has inadequate insurance, and meet certain low and moderate income requirements.

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.
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: