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): 2130125 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: East Texas Medical Center Athens  County: HENDERSO
Mailing Address: 2000 SA PALESTINE ATHENS, TX 75751

Physical Address if different from above:

Effective Date of the current policy: 03/01/2017

Date of Scheduled Revision of this policy: 03/01/2018

How often do you revise your charity care policy? ANNUALLY/AS NEEDED

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: PO BOX 7000 TYLER TX 75711

Contact Person: ROSE MARY DAVIS Title: MANAGER COMMUNITY BENEFITS
Phone: (800) 981-3869  Fax: (903) 596-3807  E-Mail RDAVIS@ETMC.ORG

Person completing this form if different from above:
Name: KAREN PARKS  Phone: (903) 676-1173
* 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.

   BY VIRTUE OF OUR EXEMPTION FROM FEDERAL AND STATE TAXES AND AS A PART OF OUR MISSION TO SERVE THE HEALTH CARE NEEDS OF OUR COMMUNITY, ETMC WILL PROVIDE CHARITY CARE TO PATIENTS WHO MEET THE CRITERIA OF OUR POLICY AND DO NOT HAVE THE FINANCIAL MEANS TO PAY FOR HOSPITAL SERVICES

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

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

      IN AND OUT PATIENT MEDICAL TREATMENT AND DIAGNOSTIC SERVICES FOR UNINSURED OR UNDERINSURED PATIENTS WHO CANNOT AFFORD TO PAY FOR THE CARE ACCORDING TO THE GUIDELINES OF OUR POLICY

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

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

   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 PATIENT WHOSE UNPAID HOSPITAL CHARGES EXCEED THEIR ABILITY TO PAY AND WHOSE REMAINING BILL WILL RESULT IN NO OBLIGATION OR A DISCOUNTED OBLIGATION TO PAY FOR THE SERVICES RENDERED, BASED ON THE ELIGIBILITY CRITERIA SET FORTH IN OUR POLICY

   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

☑ ALL ADULTS LEGALLY FINANCIALLY RESPONSIBLE
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 MAIL, ETMC 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.

   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 FROM RESOLUTION OF ALL THIRD PARTY INSURANCE AND/OR FUNDING ELIGIBILITY EFFORTS

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 ELIMINATE BILLING FOR PATIENTS RECEIVING 100% CHARITY ASSISTANCE, FOR PATIENTS RECEIVING PARTIAL ASSISTANCE A BILLING STATEMENT REFLECTING THE BALANCE AFTER CHARITY IS SENT TO THE CUSTOMER

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).

1) EMERGENCY CARE - MAINTAIN MEDICAL STAFF COMPOSITION AND CALL COVERAGE NECESSARY TO SUSTAIN TRAUMA CENTER - ALL SERVICE AREA POPULATION
2) ACCESS TO CARE - INCREASE PRIMARY CARE PROVIDERS IN RURAL COMMUNITY - ALL SERVICE AREA POPULATION

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: