**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

<table>
<thead>
<tr>
<th>Facility Identification (FID):</th>
<th>4410020</th>
<th>(Enter 7-digit FID# from attached hospital listing)***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Hospital:</td>
<td>Hendrick Medical Center</td>
<td>County: Taylor</td>
</tr>
<tr>
<td>Mailing Address:</td>
<td>1900 Pine St Abilene, TX 79601</td>
<td></td>
</tr>
<tr>
<td>Physical Address if different from above:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective Date of the current policy:</td>
<td>09/01/2015</td>
<td></td>
</tr>
<tr>
<td>Date of Scheduled Revision of this policy:</td>
<td>08/31/2016</td>
<td></td>
</tr>
<tr>
<td>How often do you revise your charity care policy?:</td>
<td>IPI amounts are adjusted annually</td>
<td></td>
</tr>
</tbody>
</table>

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

| Name of the office/department: | Resource Assistance | |
| Mailing Address:               | 1900 Pine St Abilene, TX 79601 | |
| Contact Person:                | Merle Pallarez | Title: Supervisor |
| E-Mail | mpallarez@hendrickhealth.org | |
| Phone: | (325) 670-4160 | Fax: | (325) 670-2589 | |

**Person completing this form if different from above:**

| Name: | Tave Kelly | Phone: | (325) 670-2434 |
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.

Hendrick Medical Center provides medically necessary and appropriate treatment to all individuals regardless of 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.

      Eligibility is based on the hospital's Financial Assistance Policy which includes using the Federal Poverty Guidelines, number of dependents, and gross annual income along with supportive income documents.

   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 250% for full charity, partial assistance granted on a sliding scale up to 500%

   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.

      See attached Board Policy.

   e. Does your hospital use an Assets test to determine eligibility for charity care?

      YES NO If yes, please briefly summarize method.
We use a poverty scale, please see attached Board Policy.

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 __________________________________________________________________

   This is provided in the Trauma Center, and personally delivered to patient rooms.

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
      100% for full IPIL <250% sliding scale
   ☑ d. Other, please specify up to 400% for FPIL of 500%.

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?
   60-90 days once application is complete

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).
    4410020

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).

Please see attached Community Benefits Plan

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: