**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>530510</th>
<th>(Enter 7-digit FID# from attached hospital listing)***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Hospital:</td>
<td>Seton Highland Lakes</td>
<td>County: BURNET</td>
</tr>
<tr>
<td>Mailing Address:</td>
<td>3201 S. WATER STREET, BURNET, TX 78611</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></td>
<td></td>
</tr>
<tr>
<td>Date of Scheduled Revision of this policy:</td>
<td>Reviewed every 3 years, revised as needed</td>
<td></td>
</tr>
<tr>
<td>How often do you revise your charity care policy?</td>
<td>Reviewed every 3 years, revised as needed</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: 3201 S. Water Street, Burnett, TX 78611

Mailing Address: 3201 S. Water Street, Burnett, TX 78611

Contact Person: Kim Simpson  
Title: PFS Manager

Phone: (512) 715-3362  
Fax:  
E-Mail  ksimpson@seton.org

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.
Consistent with the mission of Seton and as an Ascension Health sponsored healthcare organization, Seton will provide medically necessary services within a defined benefit structure to eligible patients who are financially or medically indigent. The amount of charitable services provided will be subject to Seton’s financial ability to absorb the cost of such services, while simultaneously ensuring financial viability. Every effort will be made to educate professional and medical staff and the public, as to the criteria and processes followed in the application of this policy. Seton will seek assistance in funding charitable services from available sources.

2. Provide the following information regarding your hospital’s current charity care policy.
   a. Provide definition of the term charity care for your hospital.
      The policy does not define the term ¿charity care¿ per se; the implied definition is medically necessary services provided to eligible patients who are financially or medically indigent and who have no/discounted obligation to pay for services rendered.
   b. What percentage of the federal poverty guidelines is financial eligibility based upon?
      Check one. 5
      
      1. <100%  4. <200%
      2. <133%  ✓  5. Other, specify 375%
      3. <150%
   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.
      Medically indigent means a person whose medical or hospital bill after payment by third-party payers exceeds a specified percentage of the patient’s annual gross income, in accordance with the network’s eligibility system, and the person is financially un
   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

[ ] See Pg 6 (Item I.2.f.f)
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 College or University scholarships, grants, fellowships, and assistantships

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 Written correspondence and Seton website

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

- 1. YES   No   If, YES, please provide name and address of the place.

   Written correspondence and Seton website, Written correspondence and Seton website

   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

During the collection process

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? Determination should be made within two weeks after receipt of complete application unless there are extenuating or unusual circumstances

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).
    530510

12. Does your hospital pay for charity care services provided at hospitals owned by others?
    YES ☑ NO

http://www.dshs.state.tx.us/chs/hosp/
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 report on community benefit activities send under separate cover via email to Dwayne Collins and JaNell Jenkins at TX DSHS.

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.

Page 3, I.2.f.5. Number of family members calculated as follows: Adults include the patient, the patient's spouse, and any dependents. Minors include the patient, the patient's mother, dependents of the patient's mother, the patient's father, and dependen
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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: