## 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>856564 (Enter 7-digit FID# from attached hospital listing)***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Hospital:</td>
<td>Childrens Medical Center Plano</td>
</tr>
<tr>
<td>County:</td>
<td>Collin</td>
</tr>
<tr>
<td>Mailing Address:</td>
<td>1935 Medical District Drive, Dallas, TX 75235</td>
</tr>
<tr>
<td>Physical Address if different</td>
<td>7601 Preston Rd, Plano, TX 75024</td>
</tr>
<tr>
<td>from above:</td>
<td></td>
</tr>
<tr>
<td>Effective Date of the current</td>
<td>02/23/2017</td>
</tr>
<tr>
<td>policy:</td>
<td></td>
</tr>
<tr>
<td>Date of Scheduled Revision of</td>
<td>02/23/2019</td>
</tr>
<tr>
<td>this policy:</td>
<td></td>
</tr>
<tr>
<td>How often do you revise your</td>
<td>As needed</td>
</tr>
<tr>
<td>charity care policy:</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: **Patient Financial Services**

Mailing Address: **1935 Medical District Drive**

Contact Person: **Loyd Skinner**

Title: **VP, Revenue Cycle**

Phone: **(214) 456-7000**

Fax: **(214) 456-1955**

E-Mail: **loyd.skinner@childrens.com**

Person completing this form if different from above:

Name: **Christopher Titsworth**

Phone: **(214) 456-3621**
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.dhs.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.dhs.state.tx.us/chs/hosp/.

I. Charity Care Policy:

1. Include your hospital’s Charity Care Mission statement in the space below.

Children's Health System of Texas (CHST) recognizes that many persons in the community require medically necessary health care services, but are uninsured, underinsured, ineligible for government health programs or otherwise without adequate financial resources to pay for these health care services. CHST is committed, to the extent of its financial ability, to make medically necessary services available for those not able to pay and not just for those who are able to pay. In order to manage its resources responsibly and to provide the appropriate level of assistance to the greatest number of persons in need, CHST has adopted the following guidelines for the provision of Charity Care (as defined below) and Discounted Care (as defined below). Accordingly, the purpose of this Policy is to describe: The eligibility criteria and application process to obtain financial assistance under this Policy; The basis for calculating amounts charged to patients eligible for financial assistance under this Policy; The method by which patients and their Families (as defined below) may apply for financial assistance; How CHST will publicize this Policy within the community served by CHST; and The limits on the amounts that CHST Providers (as defined below) will charge for emergency or other medically necessary care provided to individuals eligible under this Policy.

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 term "Charity Care" means complete and total financial assistance for the entire amount of the invoice for services rendered by the CHST Provider.

   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

   200% of Federal Poverty Level for 100% Charity care adjustments, sliding scale adjustment for 201% to 400% of Federal Poverty Level.

   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 patients are usually moderate to middle income persons who have difficulty meeting the significant financial obligation of a catastrophic illness.

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  Patient's mother and father
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 ________________________________

  - email

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.

  Ambulatory Care Pavilion Dallas, 2350 Stemmons Fwy, Dallas, TX 75207

  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 the time of pre-registration or prior to scheduled services.

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?  1-5 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  90 days ____________________________

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).
    856564

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

http://www.dhs.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 attached Community Health Implementation Strategy Link for Children's Community Reports (supporting documents): https://www.childrens.com/footer/aboutsection/about/reports-and-publications/community-reports

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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Part II

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for Inclusion in DSHS Charity Care Manual as Required
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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: