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**
2018

Facility Identification (FID): 2011890 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Memorial Hermann Health System **County:** Harris

Mailing Address: 909 Frostwood Dr, Suite 3:100 Houston, TX 77024

Physical Address if different from above: N/A

Effective Date of the current policy: 12/19/2017

Date of Scheduled Revision of this policy: 07/01/2019

How often do you revise your charity care policy? Yearly

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

Name of the office/department: Financial Assistance

Mailing Address: 909 Frostwood Dr, Suite 3:100 Houston, TX 77024

Contact Person: Amy Depedro Title: Director

Phone: (713) 338-6016 Fax: E-Mail Amy.DePedro@memorialhermann.org

Person completing this form if different from above:

Name: Rick Lyman Phone: (713) 338-4111

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.texas.gov/chs/hosp under 2018 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.texas.gov/chs/hosp/.

I. Charity Care Policy:

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

Will send by Email See Attached MHHS Policy Page 1

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

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

We provide financial assistance to patients who meet certain financial eligibility standards and are unable to pay for medically necessary health care services.

b. What percentage of the federal poverty guidelines is financial eligibility based upon? Check one.
5

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

Under 200% is one level. 100%, 200-400% is another 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**.

This is an old Term not used to comply with 501R

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 Online

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.

Online,

d. Is the application form available in language(s) other than English?

☑ YES NO

If yes, please check

Spanish ☑ ☑ Other, please specify Arabic, Chinese, Farsi, French, German, Gujarati, Hindi, Japanese, Korean, Laotian, Russian, Tagalog, Urdu and

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 gov't 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 Depend on Income, see policy

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

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 Up to 6 Months

10. How does the hospital notify the patient about their eligibility for charity care? Check all that apply. 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). Only Emergency as Medically necessary health care

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).

Will send by Email

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 eighteenth 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.texas.gov.

Name of Hospital: _____ City: _____

Contact Name: _____ Phone: _____

Suggestions/questions: