**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****
**2019**

**Facility Identification (FID):** 4513000 (Enter 7-digit FID# from attached hospital listing)***

**Name of Hospital:** SHANNON MEDICAL CENTER **County:** TOM GREEN

**Mailing Address:** PO BOX 1879 SAN ANGELO TX 76902

**Physical Address if different from above:** 120 E HARRIS

**Effective Date of the current policy:** 10/1/2019

**Date of Scheduled Revision of this policy:**

**How often do you revise your charity care policy?** 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 1879 SAN ANGELO TX 76902

Primary Contact: GLORIA ROBLEDO Primary Title: ACCOUNTING TEAM LEADER

Primary Phone: (325) 653-6741 Primary Fax: (325) 657-5712

Person completing this form if different from above:

Name: SHERYL MOON Title: BUSINESS OFFICE DIRECTOR

Phone: (325) 481-2124 Fax: (325) 657-5600

Second Person completing this form if different from above:

Name: Title:

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 2019 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.

SMC endeavors to provide assistance in the form of Charity Care of uninsured or underinsured patients of our community who are unable to pay for medical services they have received due to financial or medical indigency.

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

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

"Uninsured or underinsured patients/guarantors who are unable to make mutually agreeable financial arrangements for their medical expenses, will be considered a candidate for the Charity Care Program."

b. What percentage of the federal poverty guidelines is financial eligibility based upon? Check one.
4

1. 100%
2. <133%
3. <150%
☑ 4. <200%
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**.

Catastrophic illness will be defined as uncompensated charges exceeding 200% of total annual family income and will be eligible upon review for a Medically Indigent Care discount.

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 Shannon's Website - www.shannonhealth.com

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.

Shannon Clinic, "120 E. Beauregard San Angelo, TX 76903"

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 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 100% discount for financially indigent. Discount for medically indigent with payment responsibility not to exceed 10% of family¿s gross annual income

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? Dependent

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 8 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). Elective and Cosmetic procedures are not eligible

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 PDF document of 'Community Benefits Report for FY19

**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 nineteenth 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:**