`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**
2023

Facility Identification (FID): 2016290 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: HOUSTON METHODIST CONTINUING CARE HOSPITAL **County:** HARRIS

Mailing Address: 701 SOUTH FRY RD KATY TX 77450

Physical Address if different from above:

Effective Date of the current policy: 02/01/2014

Date of Scheduled Revision of this policy:

How often do you revise your charity care policy? UPON REVIEW OR SOONER IF NEEDED

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

Name of the office/department: FINANCE AND PATIENT ACCESS SERVICES

Mailing Address: 18500 KATY FREEWAY, HOUSTON, TEXAS 77094

Contact Person: RENEE THOMPSON Title: DIRECTOR OF BUSINESS SERVICES

Phone: 8325221187 Fax: 8325221171

Person completing this form if different from above:

Name: KARON D. JONES Phone: 8325227291

*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 2023 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: http://www.dshs.texas.gov/chs/hosp/

I. Charity Care Policy:

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

THE METHODIST HOSPITAL SYSTEM WILL PROVIDE UNCOMPENSATED OR DISCOUNTED HOSPITAL CARE TO PATIENTS THROUGH THE FINANCIAL ASSISTANCE PROGRAM. PATIENT ACCESS SERVICES AND PATIENT ACCOUNTING WILL BE RESPONSIBLE FOR REVIEWING COMPLETED FINANCIAL ASSISTANCE APPLICATION FORMS(FAAF ATTACHMENT 1B) AND DETERMINING ELIGIBILITY. THE ELIGIBILITY CRITERIA WHICH IS UPDATED ANNUALLY, RELY ON INCOME LEVELS AND MEANS TESTING INDEXED TO THE FEDERAL POVERTY GUIDELINES, UPDATED AT THE BEGINNING OF EACH CALENDAR YEAR AND AVAILABLE FROM THE FEDERAL GOVERNMENT. ELIGIBLE APPLICANTS ARE CLASSIFIED AS EITHER FINANCILLAY INDIGENT(FI) OR MEDICALLY INDIGENT(MI). THE REVIEW MAY BE CONDUCTED USING EITHER THE TRADITIONAL OR FAST TRACK METHOD.

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

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

FINANCIALLY INDIGENT(FI) SHALL REFER TO INDIVIDUAL(S) WHOSE GROSS HOUSEHOLD INCOME FALLS UNDER OR WITHIN GUIDELINES ESTABLISHED BY THE METHODIST HOSPITAL SYSTEM BASED ON 200% OR BELOW THE FEDERAL POVERTY GUIDELINES. PATIENS WHO FALL UNDER THIS CATEGORY ARE ACCEPTED FOR CARE WITHOUT OBLIGATION OR AT A DISCOUNTED RATE.

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

MEDICALLY INDIGENT(MI) SHALL REFER TO INDIVIDUALS WHOSE INSURANCE COVERATE, IF ANY, DOES NOT PROVIDE COMPLETE COVERAGE FOR ALL MEDICAL EXPENSES AND THE MEDICAL EXPENSE, IN RELATIONSHIP TO INCOME, WOULD MAKE THEM INDIGENT IF FORCED TO PAY OUTSTANDING BALANCE.

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 _____

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.

WWW.HOUSTONMETHODIST.ORG,

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

☑ YES NO

If yes, please check

Spanish ☑ 1 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. Paycheck 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 _____

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? UP TO 45 DAYS. THE COMPLETION TIME DEPENDS ON HOW QUICKLY THE PATIENT COMPLETES THE APPLICATION AND SUPPLIES SUPPORTING FINANCIAL INFORMATION.

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. 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).

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).

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 twenty-third 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: