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**
-2009-

Facility Identification (FID): 610460	(Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Valley Baptist Medical Center - Brownsville **County:** CAMERON

Mailing Address: 1040 W. Jefferson St., Brownsville, TX 78520

Physical Address if different from above: _____

Effective Date of the current policy: 01/01/2008

Date of Scheduled Revision of this policy: 02/01/2008

How often do you revise your charity care policy? annually

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

Name of the office/department: Patient Accounts

Mailing Address: 2101 Pease St., Harlingen, TX 78550

Contact Person: Mac Franklin Title: Revenue Cycle Manager

Phone: (956) 357-1250 Fax: (956) 389-6848 E-Mail mac.franklin@valleybaptist.net

Person completing this form if different from above:

Name: Eva L. Vargas Phone: (956) 389-1268

* 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 also available in Word or PDF formats at DSHS web site: www.dshs.state.tx.us/chs/hosp under 2009 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.

Valley Baptist Medical Center will properly identify aand write off charity accounts in an appropriate and timely manner.

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

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

Charity accounts are those where adequate financial resources are unavailable to pay the account within a reasonable time frame. If a patient is determined to be either financially or medically indigent the patient account is eligible to be classified as a charity account.

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 _____

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**.

An applicant whose medical or hospital bill after third party payors exceeds a specific percentage of the applicants total year income and who is unable to pay the remaining 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 by mail on request

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.

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

☐ YES NO

If yes, please check

Spanish ☐ Other, 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 When patient request payment arrangement

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?
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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 6 months

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).

Cosmetic services

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).

See attached community health needs assessment update.

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.