Facility Identification (FID): 2016144 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Intracare North Hospital County: Harris

Mailing Address: 1120 Cypress Station Drive, Houston, TX 77090

Physical Address if different from above: ________________________________

Effective Date of the current policy: 12/01/1988

Date of Scheduled Revision of this policy: 12/01/2012

How often do you revise your charity care policy? once a year

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

Name of the office/department: Administration

Mailing Address: 1120 Cypress Station Drive, Houston, TX 77090

Contact Person: Frederick Chan Title: Chief Financial Officer

Phone: (281) 893-7200 Fax: (832) 249-3599 E-Mail fchan@intracare.org

Person completing this form if different from above:

Name: ___________________________ Phone: ___________________________

* 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.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.dshs.state.tx.us/chs/hosp/.
I. Charity Care Policy:

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

In this place, courtesy governs interactions, dignity can be found, hope grows. Who cares? I care. Also to provide care in such a way that people in need will seek our help before any other.

2. Provide the following information regarding your hospital’s current charity care policy.
   a. Provide definition of the term **charity care** for your hospital.

   **Intracare North Hospital** shall maintain a written set of guidelines by which an assessment of a patient's financial status shall be made. The guidelines shall serve as the basis for a determination of eligibility for charity care. Patient eligible for charity care shall be those persons determined to be financially and medically indigent. For the purpose of this policy, charity care shall be defined as any service provided to a person who is financially or medically indigent pursuant to the hospital's eligibility system. Financially indigent shall be defined as the financial status of a person whose annual gross income does not exceed two hundreds percent of the federal poverty guidelines as published by the U.S. Department of Health & Human Services. Medically indigent shall be defined as the financial status of a person whose medical or hospital bills after payments by third payors exceed seven (7%) of the person's annual gross income and that the person is financially unable to pay the remaining portion of the medically or hospital bills. This policy shall be posted prominently and continuously in the Admitting Office. This policy shall be posted in both English & Spanish. Admitting person shall advise all patient of the available procedure for applying charity care.

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

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

   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 shall be defined as the financial status of a person whose medical or hospital bills after payments by third payors exceed seven (7%) of the person's annual gross income and that the person is financially unable to pay the remaining portion of the medically or hospital bills.

   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.

   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 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 ______________________
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?  Same Day

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?
    ☑ 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.
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

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: