

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**

-2014-

Facility Identification (FID): 3032360 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: COVENANT MEDICAL CENTER **County:** LUBBOCK

Mailing Address: 3615 19th St

Physical Address if different from above: _____

Effective Date of the current policy: 03/13/2013

Date of Scheduled Revision of this policy: 03/13/2016

How often do you revise your charity care policy? AS NEEDED FOR RELEVENCE

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

Name of the office/department: sw pATIENT FINANCIAL SERVICES

Mailing Address: 2107 OXFORD AVENUE, LUBBOCK, TEXAS 79410

Contact Person: LANA JONES **Title:** SW DIRECTOR OF PATIENT FINANCIAL SERVICES

Phone: (806) 725-5765 **Fax:** (806) 725-5356 **E-Mail** LBJONES@COVHS.ORG

Person completing this form if different from above:

Name: HARLEY CORNELSEN **Phone:** (806) 725-6654

* 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.

COVENANT HEALTH AFFIRMS ITS COMMITMENT TO SERVE ITS COMMUNITIES WITH AN ENPHASIS ON PROVIDING OPTIMAL HEALTH SERVICES AND PROGRAMS BY DEDICATING OUR EFFORTS TO ALL PERSONS REGARDLESS OF THEIR AGE, SEX, CREED, DISABILITY, NATIONAL ORIGIN, OR FINANCIAL STATUS. THESE BELIEFS HAVE LED COVENANT HEALTH SYSTEM TO DEVELOP A FORMALIZED POLICY AND PROCEDURE FOR PROVIDING FINANCIAL ASSISTANCE.

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

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

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%

BETWEEN 175% AND
300% OF FEDERAL
POVERTY 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**.

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?
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).

POPULATION HEALTH MANAGEMENT FOR ANY PATIENT NEEDING ASSISTENCE WITH HEALTHCARE DECISIONS AND OPTIONS AVBAILABLE INCLUDING NURSES FOR VISITATION AND ASSESSMENT.

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 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: