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**
2015

Facility Identification (FID): 1270573  (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Dimmit Regional Hospital County: Dimmit
Mailing Address: P.O. Box 1016, Carrizo Springs, Texas 78834
Physical Address if different from above: 704 Hospital Drive, Carrizo Springs, Texas 78834
Effective Date of the current policy: 10/12/2012
Date of Scheduled Revision of this policy: 10/01/2014
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: P.O. Box 1016, Carrizo Springs, Texas 78834
Contact Person: Michelle Chong Title: Business Office Supervisor
Phone: (830) 876-2424 Fax: (830) 876-9126 E-Mail mchong@dimmitregional.com

Person completing this form if different from above:
Name: Alma Melendez Phone: (830) 876-2424

* 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 2015 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.

Provide medically necessary healthcare for patients who seek services, including those individuals in the community who lack the means to pay for such services.

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 care is providing healthcare service to persons that do not have the ability to pay for the services needed.

   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.

      Persons may qualify as medically indigent if their hospital bill greatly exceeds their annual income.

   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

  http://www.dshs.state.tx.us/chs/hosp/
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 Mail ________________________________

   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 gov’t assistance programs such as Medicaid  
      19. Signed affidavit or attestation by patient  
      20. Veterans benefit statement  
      21. Other, please specify ________________________________

http://www.dshs.state.tx.us/chs/hosp/
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? 3 Days

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).

Persons with limited resources that are not able to travel out of the county to obtain these services due to the cost of the trip and the cost of the procedure.

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.
NOTE: This is the fourteenth 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: