

**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):** 1576070 (Enter 7-digit FID# from attached hospital listing)\*\*\*

**Name of Hospital:** Memorial Hermann Sugar Land Hospital **County:** Fort Bend

**Mailing Address:** 17500 W Grand Parkway S., Sugar Land, TX 77479

**Physical Address if different from above:** \_\_\_\_\_

**Effective Date of the current policy:** 06/04/2009

**Date of Scheduled Revision of this policy:** 05/10/2016

**How often do you revise your charity care policy?** Yearly, or as needed

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

Name of the office/department: Patient Business Services, Corporate Office

Mailing Address: 902 Frostwood, Suite 2-225, Houston, Texas 77024

Contact Person: Donna M. Poole Title: VP of Patient Access  
Operations  
donna.poole@memorialherm

Phone: (832) 658-6001 Fax: (713) 338-4388 E-Mail ann.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](http://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/](http://www.dshs.state.tx.us/chs/hosp/).

<http://www.dshs.state.tx.us/chs/hosp/>

**I. Charity Care Policy:**

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

'As part of the Memorial Hermann Healthcare System's mission to serve the healthcare needs of the community, Memorial Hermann will provide charity care to patients without financial means to pay for hospital services in keeping with the guidelines established in this policy as presently constituted or as amended from time to time. Care will be provided to all patients who present themselves for care at Memorial Hermann without regard to race, creed, color, or national origin. Those patients who are financially indigent or medically indigent will receive such care on a non-discriminatory objective basis and consistently with the continuing need for good stewardship of limited medical and financial resources.

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

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

See Current Financial Assistance Policy and the Weblink for updates, it can be found at [http://www.memorialhermann.org/financial assistanceprogram/](http://www.memorialhermann.org/financialassistanceprogram/) Financial Assistance Program Memorial Hermann Health System’s Financial Assistance Policy and Admissions Policy govern how financial assistance is provided. On the basis of these policies, a determination will be made regarding a patient’s eligibility for financial assistance. Payment from all other possible payment sources must be exhausted before a patient can be considered for the financial assistance program. For patients who do not have insurance coverage, alternate funding and payment plan options may be available. Our staff or contracted agents work with patients to identify potential options. Financial assistance may be available to patients who do not have the means to pay for their healthcare expenses and do not qualify for any government or other programs. A patient may qualify for Financial Assistance based on federal poverty guidelines. To be considered for this program, patients are required to provide financial information for the household by completing a Financial Information Form along with supporting documentation. To verify income, the most current Federal Income Tax Return should be provided. Other pieces of supporting documentation may be requested in addition to or instead of the Tax Return, including: Last two Employer paycheck stubs, written documentation from income sources, and a copy of all bank statements for the last three months. Memorial Hermann reserves the right to review an applicant’s credit report, property tax records, and/or other public or personal documents prior to a determination regarding program eligibility

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

5

- |          |                   |            |
|----------|-------------------|------------|
| 1. 100%  | 4. <200%          |            |
| 2. <133% | 5. Other, specify | <u>400</u> |
| 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**.

refers to individuals who this Hospital determines are unable to pay all or a portion of their remaining bill balance after payment, if any, by third party payors; or have outstanding account balances of at least \$5,000 owed on their Hospital bills, after crediting all health insurance payments, if any, and such account balance exceeds twenty percent (20%) of the person’s annual gross family income.s

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 email/website

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.

Corporate Business Services, 909 Frostwood, Suite 3:100, Houston, Texas 77024

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 \_\_\_\_\_

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 up to 240 days after 1st statement

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?

Depends on when all information is obtained to 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 up to six 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). Physician professional services, other services not covered include elective services, such as, but not limited to home health, Durable Medical Equipment (DME), Hospice, Rehabilitation, scheduled/non-emergent procedures and other non-emergent/urgent care. Exception to the non-covered services may be made by the individual hospital, on a case-by-case basis for continuum of care, within the parameters of this policy.

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 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](mailto:dwayne.collins@dshs.state.tx.us).

Name of Hospital: \_\_\_\_\_ City: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Suggestions/questions:**