Facility Identification (FID): 1792735  (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Pampa Regional Medical Center  County: Gray

Mailing Address: One Medical Plaza Pampa, Texas 79065

Physical Address if different from above:

Effective Date of the current policy:

Date of Scheduled Revision of this policy:

How often do you revise your charity care policy?

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

Name of the office/department: Administration

Mailing Address: One Medical Plaza Pampa, Texas 79065

Contact Person: Brad Morse  Title: CEO  bmorse@primehealthcare.com

Phone: (806) 665-5500  Fax: (806) 665-2361  E-Mail bmorse@primehealthcare.com

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 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.

2. Provide the following information regarding your hospital’s current charity care policy.
   a. Provide definition of the term **charity care** for your hospital.
      Financial assistance for patients who lack or have inadequate insurance and meet certain low to moderate income requirements.

   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 350%

   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 who do not have health insurance and are not qualified for other health coverage.

   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.

- ✔ Wages and salaries before deductions
- ✔ Self-employment income
- Social security benefits
- Pensions and retirement benefits
- Unemployment compensation
- Strike benefits from union funds
- Worker’s compensation
- Veteran’s payments
- Public assistance payments
- Training stipends
- Alimony
- Child support
- Military family allotments
- Income from dividends, interest, rents, royalties
- Regular insurance or annuity payments
- Income from estates and trusts
- Support from an absent family member or someone not living in the household
- Lottery winnings
- Other, specify: Pay Stubs or Tax Returns

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.

- ✔ By telephone
- ✔ In person
- Other, please specify

- Other, please specify

- Other, please specify

3. Are charity care application forms available in places other than the hospital?

- ✔ YES NO If, YES, please provide name and address of the place.

CMRE/HRMG, 3075 East Imperial Highway ste #200 Brea, CA 92821

http://www.dshs.state.tx.us/chs/hosp/
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? 1-30

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). Elective Procedures, services that are not emergent or stemming from an ER visit.

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).

The heart ball; American Heart Assoc Men and Women Ages 35-60 Heart disease  Go red for women; American Heart Assoc Women Ages 20-100 Heart disease in women  Quantaflo Men and Women Ages 65 and older Peripheral arterial disease  Free Prenatal Class Women 20-40 OB  Rotary Bike Giveaway Children Ages 5-15 Literacy  Womens Expo Women 20-60 Women’s Health  Harvesters Ages 10-60 Community Pride  Boy Scouts Ages 10-40 Leadership and Education  Relay for Life Events; American Cancer Society Ages 15-50 Cancer  United Way Events Ages 15-50 Community  American Cancer Society Ages 15-100 Breast Cancer 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 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: