

**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):** 1892840 (Enter 7-digit FID# from attached hospital listing)\*\*\*

**Name of Hospital:** Covenant Hospital Plainview **County:** Hale

**Mailing Address:** 2601 Dimmitt Road

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

**Effective Date of the current policy:** 04/20/2016

**Date of Scheduled Revision of this policy:** 04/20/2017

**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: Revenue Cycle Services

Mailing Address: 2601 Dimmitt Road, Plainview, Texas 79072

Contact Person: Jackie Carthel Title: SW Manager ED  
Registration Financial  
Counselor

Phone: (806) 291-3347 Fax: (806) 291-5688 E-Mail Jackie.Carthel@stjoe.org

Person completing this form if different from above:

Name: Cassie Mogg Phone: (806) 296-4265

\* 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.

SJH seeks to address patients health care and financial needs while remaining committed to the stewardship of SJH resources. To ensure that SJH obtains appropriate reimbursement for services provided, several payment options and programs are available to support the needs of uninsured and underinsured patients. When it is determined that a payment solution cannot be obtained through such payment options and programs, then the patient is provided with information about the SJH Financial Assistance Program (FAP).

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

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

Medically necessary hospital services provided at a discount or at no cost to a patient who lacks or has inadequate insurance and meets defined low-income requirements.

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

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- 1. 100%
- 2. <133%
- 3. <150%
- 4. <200%
- 5. Other, specify
- More than 175%,  
Less than 300%

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 who are not eligible for other health care coverage.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 \_\_\_\_\_

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 \_\_\_\_\_

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? Up to 15 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 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).

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).

Diabetes Awareness: The Diabetes Education department speaks frequently at organizations though out the community on health related issues such as diabetes, heart disease, blood pressure, and nutrition. Additionally, this department participates annually in the Step Out to Fight Diabetes 5K walk/run and raises money for the ADA. The diabetes forum is a one hour support group which meets once per month to offer diabetes education and motivation to those patients needing ongoing support. This course is free of charge and open to the community without a physician referral. HK2020: Healthy Kids 2020 was created in partnership with local community businesses and civic organizations to positively impact the health of our next generation by offering events that promote a healthy body, a healthy mind and a healthy spirit. This club was created in an effort to address the need to reduce and/or prevent childhood obesity and is free of charge to children and their families through out Hale County. Annual Health Fairs: The community benefits department organizes and holds at least one community wellness celebration, in partnership with other healthcare providers through out Hale County, by providing education & information about our services via literature, point of care screenings, demonstrations, poster boards, and hands on learning. Our team also participates in health fairs and wellness screenings at other businesses as needed.

**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:**