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): 4396510  (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: TEXAS HEALTH HARRIS METHODIST HOSPITAL ALLIANCE County: TARRANT

Mailing Address: 10864 TEXAS HEALTH TRAIL; FORT WORTH, TX 76244

Physical Address if different from above: 

Effective Date of the current policy: 10/26/2015

Date of Scheduled Revision of this policy: 

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 OPERATIONS

Mailing Address: 500 E. BORDER ST. SUITE 1200, ARLINGTON, TX 76010

Contact Person: PATT LOWE Title: DIRECTOR PATTLLOWE@TEXASHEALTH.ORG

Phone: (682) 236-3426 Fax: E-Mail LTH.ORG

Person completing this form if different from above:

Name: LAURA STURGEON Phone: (254) 786-2001

* 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:

** 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.

In furtherance of our charitable health care mission, hospitals affiliated with Texas Health Resources provide charity care to persons unable to pay for medically necessary treatments.

2. Provide the following information regarding your hospital’s current charity care policy.
   a. Provide definition of the term **charity care** for your hospital.

      The unreimbursed cost of providing, funding or otherwise financially supporting health care services on an inpatient or outpatient basis to a patient classified as financially or medically indigent.

   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

   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.**

      A person whose medical or hospital bills, after payment by third-party payers, exceed a specified percentage of the patient’s annual gross income and the patient is unable to pay the remaining bill.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

      Responsible person's income

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

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

Hospital personnel proactively distribute

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

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

Business Operations, 500 E. Border St Ste 1200, Arlington, TX 76010

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? within 30 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). Policy covers medically necessary services. Charity is generally not available for cosmetic type procedures that may be performed within the hospital.

12. Does your hospital pay for charity care services provided at hospitals owned by others?
    YES ☑ NO

http://www.dshs.state.tx.us/chs/hosp/
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).

See the attached "Texas Health Resources Community Health Improvement Program Highlights 2015."

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.

For additional information concerning the community benefit activities of this hospital and other hospitals related to Texas Health Resources, please see our 2015 Annual Report of Charity Care and Community Benefits filed with the Texas Department of State Health Services, Center for Health Statistics.
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: