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): 4853790  (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: United Regional Health Care System  County: Wichita
Mailing Address: 1600 Eleventh Street
Physical Address if different from above: 

Effective Date of the current policy: 09/01/2015
Date of Scheduled Revision of this policy: 09/01/2017

How often do you revise your charity care policy? 3 years unless required earlier

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

Name of the office/department: Business Office/Collections
Mailing Address: 1600 Eleventh Street
Contact Person: Jeri Kaspar  Title: Director/Patient Accounting
Phone: (940) 764-7937  Fax: (940) 764-8315  E-Mail jkaspar@unitedregional.org

Person completing this form if different from above:
Name: Tim Garrett  Phone: (940) 764-3039

* 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.

By virtue of its exemption from federal and state taxes and as a part of the Hospital’s mission to serve the health care needs of the community, United Regional Health Care System Inc. will provide Financial Assistance to patients who meet the criteria of this policy and do not have the financial means to pay for hospital 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.

   Emergent or Medically Necessary inpatient and outpatient services for uninsured or underinsured patients who cannot afford to pay for hospital services according to the guidelines of this Policy. Financial assistance does not include contractual allowances from government programs and Insurance, or Uninsured Patient Discounts, but may include insurance co-payments or deductibles, or both as well as exhausted benefits. Qualified patients will have no obligation, or a discounted obligation to pay for any services received which are deemed to be eligible under the Hospital’s Financial Assistance Policy.

   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 175%

   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 Medically Indigent patient is a person with a catastrophic illness or injury whose unpaid hospital charges exceed their ability to pay and their gross household income falls within the threshold outlined in this policy. To be eligible under the Hospital’s Financial Assistance Policy as a Medically Indigent patient, the patient’s gross annual income cannot exceed 400% of the current Federal Poverty Guidelines for the number of eligible dependents and the amount owed by the patient on the hospital bill after payment by third-party payers must meet or exceed 20% of their annual gross household income. Patients completing the Hospital Financial Assistance Application and determined to be eligible as a medically indigent patient will have their financial obligation discounted by 65% or reduced to no more than 20% of their yearly household 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

http://www.dshs.state.tx.us/chs/hosp/
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 Online at http://www.unitedregional.org

☐ 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

http://www.dshs.state.tx.us/chs/hosp/
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?
   Average is within 10 working days of receipt of completed form.
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). Patients whose outpatient services are determined to be elective or any type of service that is considered to be cosmetic and/or not medically necessary or that is designated as a Cash only procedure will not be eligible for Financially or Medically Indigent Charity. Patients receiving the hospital's pre-set cash only procedures such as Gastric-Bypass are not eligible for additional discounts of any type.

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).

United Regional files details of its community benefits in an Annual Report of Community Benefits filed annually with the Wichita County Appraisal District and others. Additionally, United Regional participates in the Delivery System Reform Incentive Program under the 1115 Waiver administered by the Health and Human Services Commission. As part of the five year program, United Regional is engaged in projects to improve access to primary care for low income individuals in our community. United Regional is participating collaboratively in improving access to specialty care for low income or under-served sections of our community. Other projects under the program include improving transitional care teams, expanding access to palliative care as well as other reforms.

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: