| **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**** |
| **2019** |

Facility Identification (FID):   3691545   (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Parmer County Community Hospital Inc   **County:**   PARMER

Mailing Address: "1307 Cleveland, Friona, TX 79035"

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: Business Office

Mailing Address: "1307 Cleveland, Friona, TX 79035"

Primary Contact: Gayla Quillan   Primary Title: CEO

Primary Phone: (806) 250-2754   Primary Fax: (806) 250-2081

Person completing this form if different from above:

Name: Roxy Lucero   Title: Financial Counselor

Phone: (806) 250-2754   Fax: (806) 250-2031

Second Person completing this form if different from above:

Name: Dawna Campos   Title: (806) 250-2754

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.texas.gov/chs/hosp under 2019 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.texas.gov/chs/hosp/..

I. Charity Care Policy:

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

"The purpose of this Financial Assistance Policy (""FAP"") is to specify: &#61623: Eligibility criteria for Financial Assistance in the form of free or discounted care: &#61623: How to apply for Financial Assistance: &#61623: How the Hospital caclulates amounts charged to patients: &#61623: How the FAP is widely publicized within the community served by the Hospital "

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

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

"Consistent with its mission to deliver compassionate, high-quality, affordable healthcare services, and to advocate for the poor and underserved, Parmer Medical Center will provide care, without discrimination, for emergency medical conditions regardless of people's ability to pay."

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 210%
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**.

"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 payers, after crediting all health insurance payment, if any and such accoun balance exceeds 20% of the person's annual gross family 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

3. All family members

☑   4. All household members

5. Other, please explain

2

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   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.

        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 _____

4

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? >10

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. 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). services provided in a Emergency Room setting that are deemed non-emergent by the physician/provider. Services not covered or deemed medically necessary by Medicare &/ Medicaid. Services performed/billed by a third party. Physician services related to inpatient healthcare services received.

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).

 "Chronic Care: Parmer Medical Center proposes to expand management of Chronic Care diseases in order to address some of the healthcare issues introduced in the community needs assessment (CNA). Chronic diseases such as Diabetes, Chronic Obstructive Pulmonary Disease and Heart Disease affect a large number of our population. The implementation of a Chronic Disease Management program will assist in meeting the needs of those who struggle with their disease, compliance with treatment, and complications of the disease process."

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.

DSHS/CHS/ASCBS-Part II//2-2020/Form# F25-11047   http://www.dshs.texas.gov/chs/hosp/

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 eighteen 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.texas.gov.

Name of Hospital: _____ City: _____

Contact Name: _____ Phone: _____

Suggestions/questions:

7