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** 2021

4716028 (Enter 7-digit FID# from attached hospital listing)*** Facility Identification (FID): Huntsville Community Hospital, Inc dba Huntsville Memorial Hospital Name of Hospital: County: Walker Mailing Address: PO Box Huntsville, Texas 77342-4001 **Physical Address if different from above:** 110 Memorial Hospital Drive, Huntsville, Texas 77340 **Effective Date of the current policy:** 02/28/2020 **Date of Scheduled Revision of this policy:** 02/28/2023 How often do you revise your charity care policy? Annually Provide the following information on the office and contact person(s) processing requests for charity care. Name of the office/department: Revenue Cycle PO Box 4001, Huntsville, Texas 77342-4001 Mailing Address: Executive Director, Revenue Title: Contact Person: Anna Smith Cycle Fax: Phone: (936) 435-7591 (936) 435-7527

Person completing this form if different from above:

Name: Lisa B. Warner

Phone: (936) 291-4523

^{*}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: https://www.dshs.texas.gov/chs/hosp/hosp3.aspx under 2021 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: http://www.dshs.texas.gov/chs/hosp/

I. Charity Care Policy:

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

Huntsville Memorial Hospital shall contribute appropriate resources, advocacy and community support to promote the health status of the community, which it serves, within its economic ability to do so. Financial assistance will be provided to patients with a demonstrated inability to pay.

- 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 with a demonstrated inability to pay.

b. What percentage of the federal poverty guidelines is financial eligibility based upon? Check one. 5

1.100%

4. <200%

2. <133%

% of FPL

- 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?

Medically Indigent. ¿Medically Indigent¿ means a patient whose medical orhospital bills from all related or unrelated providers, after payment by all thirdparties, exceed 10% of such patient¿s Yearly Household Income, whose YearlyHousehold Income is greater than 200% but less than or equal to 400% of theFPG, and who is unable to pay the outstanding patient account balance. TheseMedically Indigent patients are eligible for a discount on outstanding patientaccount balances as set forth in Part 2 of the Financial Assistance EligibilityDiscount Guidelines (Attachment A)

- e. Does your hospital use an Assets test to determine eligibility for charity care?

 ☑ YES NO If yes, please briefly summarize method. Determination of eligibility for financial assistance will be in accordance with procedures that may involve (a) an application process, in which the patient or the patient's guarantor is required to supply information and documentation relevant to making a determination of financial need; and/or (b) the use of credit reports and other publicly available information that provide information on a patient's or a patient's guarantor's ability to pay.
 - 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			
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	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			
\square	7. Worker's compensation			
	8. Veteran's payments			
	9. Public assistance payments			
	10. Training stipends			
	11. Alimony			
	12. Child support			
	13. Military family allotments			
	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 D	pes 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			
Ø	3. Other, please specify <u>via email</u>			
	c. Are charity care application forms available in places other than the hospital?			

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d. Is the application form available in language(s) other than Engl	ish?
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☑ YES NO

If yes, please check

Spanish

☐ 1 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. Paycheck remittance
 - ☑ 4. Worker's compensation
 - ☑ 5. Unemployment compensation determination letters

 - ☑ 7. Statement from employer
 - ☑ 8. Social security statement of earnings
 - ☑ 9. Bank statements
 - ☑ 10. Copy of checks
 - ☑ 11. Living expenses

 - ☑ 13. Copy of bills
 - ☑ 14. Mortgage statements

 - ☑ 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

	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
$\overline{\mathbf{A}}$	b. During hospital stay
$\overline{\checkmark}$	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
\square	d. Other, please specify see policy
7. Is there a c	harge for processing an application/request for charity care assistance?
YES 5	I NO
	days does it take for your hospital to complete the eligibility determination process? No longer following the receipt of a complete application with required supporting documentation.
9. How long d	pes the eligibility last before the patient will need to reapply? Check one.
	a. Per admission
	b. Less than six months
	c. One year
\square	d. Other, specify 6 months
	the hospital notify the patient about their eligibility for charity care? Check all that apply. Il 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:
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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). Additional Document will be sent.

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

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NOTE: This is the twenty-first 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:		