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**
2020

Facility Identification (FID): 2012018 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Texas Children's Hospital **County:** Harris

Mailing Address: 6621 Fannin Street, Houston, TX 77030

Physical Address if different from above:

Effective Date of the current policy: 09/06/2019

Date of Scheduled Revision of this policy: 10/01/2020

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: Patient Financial Services

Mailing Address: 6621 Fannin Street, Mail Code 2-4300, Houston, TX 77030

Contact Person: Robert Simon Title: Director Govt Reim & Rpt

Phone: (832) 824-2918 Fax: (832) 825-8847

Person completing this form if different from above:

Name: Enrique Gonzalez Phone: Assistant Director

*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 2020 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: https://www.dshs.texas.gov/chs/hosp/default.shtm.

I. Charity Care Policy:

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

Texas Children s Hospital, Texas Children s Physician Services Organization, and Texas Children s Women s Specialists (collectively referred to herein as TCH) are committed to providing the highest quality care to its patients. TCH recognizes that some patients and/or their families may be unable to pay for all or a portion of the services provided by TCH and its substantially related entities. In furtherance of its charitable mission and values, TCH provides financial assistance to patients and/or their families who are low-income, uninsured or underinsured, ineligible for government health care programs, and who are otherwise unable to pay some or all of the bills related to services deemed medically necessary by Medicare, Medicaid, or industry standards. Financial assistance also may be available to other patients, and for other services, determined on a case-by-case basis in accordance with the procedures set forth herein.

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

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

Includes the following: Financial Assistance: A full or partial reduction in charges incurred at TCH and its substantially related entities to patients for emergency or medically necessary services who have qualified for a discounted rate in accordance with the provisions of this Financial Assistance Policy. An Uninsured Self-Pay Patient or Under-insured Patient for the relevant service and who is not eligible for coverage through a Government Healthcare Program or other insurance, and who has Family Income less than 400% of FPL, may be eligible to receive Financial Assistance in the form of discounted charges. Financially Indigent: A patient who TCH has determined to be unable to pay some or all of the patient s bills due to the Family Income of the patient and/or the patient s family being below specified thresholds based on the FPL and/or because their monetary assets are below specified thresholds. Medically Indigent: A patient who TCH has determined to be unable to pay some or all of the patient s bills related to services deemed medically necessary by Medicare, Medicaid and Insurance industry standards, because such bills exceed a certain percentage of the Family Income and/or assets of the patient and/or the patient s family (e.g., due to catastrophic cost or other conditions), even though the patient and/or the patient s family have Family Income or assets that disqualify them from being Financially Indigent.

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

4

1. 100%
☑ 4. <200%
2. <133%
5. Other, specify _____
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**.

Medically Indigent is defined as a patient who TCH has determined to be unable to pay some or all of the patient s bills related to services deemed medically necessary by Medicare, Medicaid and Insurance industry standards, because such bills exceed a certain percentage of the Family Income and/or assets of the patient and/or the patient s family (e.g. due to catastrophic cost or other conditions), even though the patient and/or patient s family have Family Income or assets that disqualify them from meeting the criteria for financially indigent.

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 By Email

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 ☑ 1 Other, please specify Arabic and Vietnamese

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

☑ 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 Requests for future services

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? 30

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 Six Months

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 By Email

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 are expected to cooperate with the application and review process. A parent¿s failure to cooperate in applying for a government program or financial assistance may be a consideration to deny Financial Assistance. Non medically necessary services would be reviewed by the Financial Assistance Committee as a possible exception for financial assistance

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).

See the attached community benefit implementation plan

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. A patient seeking Financial Assistance generally must complete an application. However, if applicable, Presumptive Eligibility may be determined in lieu of reviewing a Financial Assistance application. Presumptive Eligibility: A patient who has not submitted a completed application for Financial Assistance, but whose circumstances fit within one or more of the following criteria Homeless; Eligible for Medicaid or CSHCN, but not on the date of service or for a non-covered service; Enrolled in governmental programs for low-income individuals and program funds are not available (i.e. budget shortfall); Referred for services by the Harris County Health System having eligibility criteria; and Identified utilizing third party software, such as propensity to pay/financial assistance eligibility/enrollment as having eligibility criteria in accordance to this Financial Assistance Policy.

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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: