`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**
2022

Facility Identification (FID): 1130935 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Children's Health **County:** Dallas

Mailing Address: 1935 Medical District Dr, Dallas, TX 75235

Physical Address if different from above:

Effective Date of the current policy: 10/11/2018

Date of Scheduled Revision of this policy: 10/11/2022

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 Access Services

Mailing Address: 1935 Medical District Drive, Dallas, TX 75235

Contact Person: Financial Counselor Title: Financial Counselor

Phone: (214) 456-7000 Fax:

Person completing this form if different from above:

Name: Phone:

* 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 2022 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.

Children s Health System of Texas (CHST) recognizes that many persons in the community require medically necessary health care services, but are uninsured, underinsured, ineligible for government health programs or otherwise without adequate financial resources to pay for these health care services. CHST is committed, to the extent of its financial ability, to make medically necessary services available for those not able to pay and not just for those who are able to pay. In order to manage its resources responsibly and to provide the appropriate level of assistance to the greatest number of persons in need, CHST has adopted the following guidelines for the provision of Charity Care (as defined below) and Discounted Care (as defined below). Accordingly, the purpose of this Policy is to describe: The eligibility criteria and application process to obtain financial assistance under this Policy; The basis for calculating amounts charged to patients eligible for financial assistance under this Policy; The method by which patients and their Families (as defined below) may apply for financial assistance; How CHST will publicize this Policy within the community served by CHST; and The limits on the amounts that CHST Providers (as defined below) will charge for emergency or other medically necessary care provided to individuals eligible under this Policy.

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

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

e term "Charity Care" means complete or partial financial assistance for the amount of the invoice for services rendered by the CHST Provider.

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

1. 100%
2. <133%
3. <150%
4. <200%
☑
5. Other, specify 200% of Federal Poverty Level for100% Charity care adjustments, sliding scale adjustment for 201% to 400% of Federal

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 patients are usually moderate to middle income persons who have difficulty meeting the significant financial obligation of a catastrophic illness.

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 Family Income

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 email and print forms from childrens.com 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 ☑ 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

☑ 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 At the time of pre-registration or prior to scheduled 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? 1-5 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. 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). Certain high cost specialized treatment may not be eligible under the Financial Assistance policy because reasonable limits must be established for the amount of financial assistance that can be furnished to the intended recipients to ensure the continued financial viability of Children s and its affiliates. Financial counseling always takes place to unfunded patients regarding financial options. Referrals to other medical facilities would also be explored.

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 attached Community Health Needs Assessment and Implementation Strategy Link for Children's Health Community Reports (supporting documents): https://www.childrens.com/keeping-families-healthy/dfw-childrens-health-assessment

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.

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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: