ANNUAL STATEMENT OF COMMUNITY BENEFITS STANDARD 2020 TEXAS NONPROFIT HOSPITALS

Part I

Please Check "one" your ownership: *

(x) Not-For-Profit

( ) For-Profit (received Medicaid Disproportionate Share Funds)

( ) Public

( ) For-Profit

3032377 **2020 ASCBS** 6742377
Grace Medical Center
Lubbock LUBBOCK
TYPE: NP DISPRO:
REQUIRED TO REPORT ASCBS: **YES**

Are you reporting as part of a hospital system? ( ) Yes (x) No

III HOSPITAL SYSTEMS - List all the hospitals included in this system report. Refer to the instructions on the back of this page in completing this section.

III	Community Benefits Contribution*	Net Patient Revenue (NPR)**	Miles From System Office	Name of Hospital	Physical Address, City, State, Zip
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
TOTAL:					

* The sum of these contributions should equal the entry in II.E (Section II follows Worksheet 5).

** The sum of net patient revenue should equal the entry in STDI1 (Standards Section follows Section II).

ESTIMATED UNREIMBURSED COSTS OF INPATIENT AND OUTPATIENT CHARITY CARE PROVIDED - 2020

Total Billed Charges for Charity Care Provided (based on 2020 audited fiscal year): (exclude bad debt)

.

W1A.	**Financially Indigent**	**Medically Indigent**	**Total Charity Care Charges**
Inpatient	479,279	7,074	486,353
Outpatient	3,766,901	55,599	3,822,500
Total	4,246,180	62,673	(a) 4,308,853

Cost to Charge Ratio Calculation (based on 2019 audited fiscal year):

W1B1. **2019** Gross Patient Service Revenue1, 2;..... (b) 259,958,055

W1B2. **2019** Total Patient Care Operating Expenses1,3.....(**Bad Debt should be treated as a Deduction)** ..... (c) 55,415,051

W1B3. **Cost to Charge Ratio (Divide (c) by (b)) (please report the ratio as a decimal 0.0000)**
*****THIS IS A PRE-CALCULATED FIELD.** (d) 0.2132

W1C. **Estimated Costs of Charity Care Provided ((a) x (d))** ..... (e) 918,647

Payments Received for Charity Care Provided: (based on 2020 audited fiscal year)

W1D1. Third-Party Payments..... 0

W1D2. Payments from Patients..... 0

W1D3. Other Payments (4) (Public hospitals report tax appropriations relative to charity care here) 0

W1D4. **Total Payments Received for Charity Care Provided**.....
*****THIS IS A PRE-CALCULATED FIELD.** (f) 0

W1E. **Estimated Unreimbursed Costs of Charity Care Provided ((e) - (f))5**..... * (g) 918,647

1 Use audited data for FY 2019 to complete the Cost to Charge Ratio Calculation section of this worksheet for FY 2020.

2 Gross Patient Service Revenue excludes Medicaid Disproportionate Share Hospital payments.

3 Total Patient Care Operating Expenses -**(Bad Debt should be treated as a deduction) excludes contractual adjustments.**

4 Do not include charitable contributions and grants received by the hospital.

5 Report zero (0) in (g) if total estimated costs of charity care provided (e) minus total payments (f) is a negative value.

***Please take a brief second to fill out the four question feedback survey in the link below.**

https://tcnws.co1.qualtrics.com/jfe/form/SV_0lENJ4LgFt35DDv

"I verified W1AA1 and W1B1 are the same amounts for the 2019 Gross Patient Revenue. This is consistent with what was filed on last year's report."
Per M. Daniels on 6/24/2021 by L.J.

CALCULATION OF THE RATIO OF COST TO CHARGE - 2019

C alculation of initial Ratio of Cost to Charge

W1AA1. Total Patient Revenues (from **2019** Medicare Cost Report1, Worksheet G-3, Line 1) (a) 259,958,055

W1AA2. Total Operating Expenses (from **2019)** Medicare Cost Report1, Worksheet A, Line 118, Col. 7 (b) 57,058,887

W1AA3. **Initial Ratio of Cost to Charge ((b) divided by (a))**
*****THIS IS A PRE-CALCULATED FIELD.** (c) 0.2195

Application of Initial Ratio of Cost to Charge to 2019 Bad-Debt Expense

W1AB1. Bad-Debt Expense2 (from **2020** audited financial statement covering your reporting period) (d) 4,844,292

W1AB2. Multiply "Bad-Debt Expense" by "Initial Cost to Charge Ratio" to determine allowable Bad-Debt Expense ((d) x (c))
*****THIS IS A PRE-CALCULATED FIELD.** (e) 1,063,322

W1AB3. **Add the allowable "Bad-Debt Expense" to " Total Operating Expenses" ((b) + (e))**
*****THIS IS A PRE-CALCULATED FIELD.** (f) 58,122,209

W1AC. **Calculation of Ratio of Cost to Charge ((f) divided by (a)) (Please report the ratio as a decimal)** (g) 0.22358

NOTE:This is Worksheet 1-A from the 1994 Annual Statement of Community Benefits Standard form.

1. Use the **PRIOR** year cost report regardless of status of review. For example, use Medicare Cost Report data for FY 2019 to complete the calculation of initial Ratio of Cost to Charge section of this worksheet.

2. Bad debt expense is defined as the provision for actual or expected uncollectibles resulting from the extension of credit.

Additional cost areas that are not reflected in the above calculations may be identified on the back of this form. Do not include these costs in worksheet computations.

Worksheet 1-A (continued)

Cost Area	Medicare Cost Report Reference*	**Amount**

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY.
To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

Support to Financially Indigent Patients Provided Through Others 2019

Funding to: W2A

W2A.	Other Nonprofit	Public	Total
Outpatient Clinic	0	0	0
Hospital	0	0	0
Other Health Care Organizations	_____	0	0
Total Funding to Others	0	0	0

Financial Support to:

W2B.

W2B	Other Nonprofit	Public	Total
Outpatient Clinic	0	0	0
Hospital	0	0	0
Other Health Care Organizations	0	0	0
Total Other Financial Support	0	0	0

.

W2C.	Other Nonprofit	Public	Total
Total Support Provided Through Others:	0	0	0

W2D. **Less: Payments allocated** (c) 0

W2E. **Total Unreimbursed Support Provided Through Others ((a.3. + b.3.) - (c))** (d) 0

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY. DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).

To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

ESTIMATED UNREIMBURSED COSTS OF GOVERNMENT-SPONSORED INDIGENT HEALTH CARE - 2020

Worksheet 3

Billed Charges for Government-sponsored Indigent Health Care Provided:(Do not include Medicare or Non-government charges.)

W3A.	**Inpatient**	**Outpatient**	**Total**
Medicaid(include Medicaid Managed Care charges; exclude Medicaid Disproportionate Share AND 1115 WAIVER PAYMENTS payments)	310,881	5,577,225	5,888,106
State Government (CSHCN, Primary Care, Kidney Health, etc.)	0	133,277	133,277
Local Government (County Indigent Health Care, other)	0	0	0
Other Government	0	0	0
Total Billed Charges	310,881	5,710,502	6,021,383

W3B1. **Ratio of Cost to Charge (Worksheet 1, Item d)** (Please report the ratio as a decimal) *****THIS IS A PRE-CALCULATED FIELD.** (b) 0.2132

W3B2. **Estimated Costs of Government-sponsored Indigent Health Care Provided ((a) x (b)) ***THIS IS A PRE-CALCULATED FIELD.** (c) 1,283,758

Payment Received for Government-sponsored Indigent Health Care Provided:(Do not include Medicare or non-government payments received.)

W3C1. Medicaid (include Medicaid Managed Care payments; exclude Medicaid Disproportionate Share Hospital payments) 515,358

W3C2. Medicaid Disproportionate Share Hospital payments 0

w3c22. Uncompensated Care Payments

900,563

W3C3. State Government (CSHCN, Primary Care, Kidney Health, etc.) 6,039

W3C4. Local Government (County Indigent Health Care, other). 0

W3C5. Other Government. **Champus Payments, VA and DSRIP should not be reported here; report Champus Payments in Worksheet 4B only)(Champus Payments and DSRIP "SHOULD NOT" be reported here; report "CHAMPUS Payments only in Worksheet 4b.)** 0

W3C5A. Please specify source of Other Government payments

_____

W3C6. **Total Payments ***THIS IS A PRE-CALCULATED FIELD.** (d) 1,421,960

W3D. **Estimated Unreimbursed Costs of Government-sponsored Indigent Health Care ((c) - (d))1** 0

(e)

(1) Report zero (0) in (e) if estimated costs of government-sponsored indigent health care provided (c) minus total payments (d) is a negative value.

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY. DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).

To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

UNREIMBURSED COSTS OF PROVIDING COMMUNITY BENEFITS -2020

Worksheet 4-A

Unreimbursed Costs of Subsidized Health Services:

W4AA1.	Emergency Care		0
W4AA2.	Trauma Care		0
W4AA3.	Neonatal Intensive Care		0
W4AA4.	Freestanding Community Clinics, e.g., rural health clinics		0
W4AA5.	Collaborative effort with local government(s) and/or private agency in preventive medicine, e.g., immunization program		0
W4AA6.	Other Services		0
W4AA7.	**Total** *****THIS IS A PRE-CALCULATED FIELD.**	(a)	0
W4AB1.	**Donations Made by the Hospital**	(b)	0
W4AB2.	**Unreimbursed Research-Related Costs**	(c)	0

Unreimbursed Education - Related Costs:

W4AC1.	Education of physicians, nurses, technicians and other medical professionals and health care providers	0
W4AC2.	Scholarships and funding to medical schools, colleges and universities for health professions education	0
W4AC3.	Education of patients concerning diseases and home care in response to community needs	0
W4AC4.	Community health education through informational programs, publications and outreach activities in response to community needs	0
W4AC5.	Other educational services	0

W4AC6. **Total**
*****THIS IS A PRE-CALCULATED FIELD.** (d) 0

W4AD. **Total Unreimbursed Costs of Providing Community Benefits ((a) + (b) + (c) + (d))**
*****THIS IS A PRE-CALCULATED FIELD***.** (e) 0

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY. DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).
To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

EST. UNREIMBURSED COSTS OF INPAT./OUTPAT. MEDICARE, CHAMPUS AND OTHER GOV'T-SPONSORED PROGRAMS - 2020

Worksheet 4-B

Total Billed Charges for Medicare *(INCLUDE MEDICARE MANAGED CARE)*, CHAMPUS, and Other Government (DO NOT REPORT DSRIP)-sponsored

Health Care Provided: (Do not include Medicaid charges or other government charges previously reported on worksheet 3.)

W4BA1.	Inpatient	11,742,915	
W4BA2.	Outpatient	92,293,648	
W4BA3.	**Total Billed Charges ***THIS IS A PRE-CALCULATED FIELD***.**	(a) 104,036,563	
W4BB1.	**Ratio of Cost to Charge (Worksheet 1, Item d) (Please report the ratio as a decimal 0.0000) ***THIS IS A PRE-CALCULATED FIELD***.**		(b) 0.2132
W4BB2.	**Estimated Costs of Government-sponsored Health Care Provided (a x b) ***THIS IS A PRE-CALCULATED FIELD***.**		(c) 22,180,595

Payments Received for Care Provided: (Do not include Medicaid payments received.)

W4BC1.	Government Payments	14,538,736	
W4BC2.	Payments from Patients	1,365,439	
W4BC3.	Other Payments	0	
W4BC4.	**Total Payments ***THIS IS A PRE-CALCULATED FIELD***.**	(d) 15,904,175	
W4BD.	**Estimated Unreimbursed Costs of Government-sponsored Health Care Provided ((c) - (d))2**		(e) 6,276,420

1. Do not include charitable contributions and grants.

2. Report zero (0) in (e) if estimated cost of government-sponsored health care provided (c) minus total payments (d) is a negative value.

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY. DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).
To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

ESTIMATED VALUE OF TAX EXEMPT BENEFITS
2020

Worksheet 5

Franchise Tax:

W5A. The greater of Fund Balance x 0.25 percent (.0025); -OR-

Net Income plus Officers' and Directors' Compensation x 4.5 percent (.045) (a) _____

Ad Valorem Taxes

.

		Amount of Taxes
County Property Tax (Appraised Value of Property (Real andPersonal) x Tax Rate)		_____
School District Tax (Appraised Value of Property x Tax Rate)		_____
Hospital District Tax (Appraised Value of Property x Tax Rate)		_____
Other Property Taxes (Appraised Value of Property x Tax Rate)		_____
W5B5. **Total Estimated Ad Valorem Taxes**	(b) _____	

Sales Tax

W5C1. Supplies expense less pharmacy supplies expense _____

W5C2. Lease or rental expense _____

W5C3. Capital Purchases _____

W5C4. Total Estimated Taxable Purchases (1) _____

W5C5. Sales Tax Rate.....(**Please report RATE (.0000), not a percent**) (2) _____

W5C6. **Total Estimated Sales Tax (Multiply (1) by (2)) ***THIS IS A PRE-CALCULATED FIELD.** (c) _____

Contributions

W5D1. Nondesignated and Charitable Cash Donations received by the hospital _____

W5D2. Fair Market Value of Nondesignated and Charitable In-Kind _____

Donations

W5D3. **Total Contributions** (d) _____

Tax-Exempt Bond Financing

W5E1. Average Outstanding Bond Principal x Prevailing Interest Rate at Time of Issuance (1) _____

W5E2. Actual Interest Expense for the Reporting Period (2) _____

W5E3. Value of Tax-Exempt Bond Financing ((1) - (2)) (e) 0

W5F. **TOTAL ESTIMATED VALUE OF TAX EXEMPT BENEFITS ((a)+(b)+(c)+(d)+(e))** (f) _____

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY. DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).
To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

II. CHARITY CARE, GOVERNMENT-SPONSORED INDIGENT HEALTH CARE, AND OTHER COMMUNITY BENEFITS INFORMATION - 2020

IIA. Unreimbursed costs of charity care

	Hospital	System Total
IIA1. Unreimbursed costs of providing care to financially and medically indigent (Worksheet 1, (g))	918,647	0
IIA2. Support to financially indigent patients provided through others (Worksheet 2, (d))	0	0
IIA3. Unreimbursed costs of charity care (A.1. + A.2.)	918,647	0
IIB. Unreimbursed costs of providing Government-sponsored Indigent Health Care (Worksheet 3, (e))	0	0
IIC. Total Charity Care and Government-sponsored Indigent Health Care (A.3. + B.)	918,647	0
IID. Unreimbursed costs of providing Other Community Benefits (Worksheets 4-A, (e) + 4-B, (e))	6,276,420	0
IIE. Total Charity Care, Government-sponsored Indigent Health Care, and Other Community Benefits (C. + D.)	7,195,067	0

If you're reporting as a system, please provide system aggregate data for sections I, II, and III

PLEASE PRESS SAVE OR SAVE AND VALIDATE TO CONTINUE OUR WORKSHEET SECTION OF THE SURVEY.DO NOT LEAVE ANY SECTION BLANK, REPORT ZERO (0).

To navigate the worksheet pages of the Annual Statement of community benefits standards for Texas non profit hospitals please go to worksheet 1 and push save or save and validate. If you decide to exit the survey and continue at a later date go back to worksheet 1 and push save to continue to where you left off.

STD **STANDARDS - Please check the appropriate box (A, B or C) below and provide the requested information.**

TaxID. Taxpayer Number: 264021016

		Hospital	System
STDI1.	Net Patient Revenue (include Medicaid Disproportionate Share Hospital payments):**(exclude DSRIP= the incentive payments from "Net Patient Revenue) TREAT BAD DEBT AS A DEDUCTION FROM NET REVENUE**	55,098,212 *Confirmed	

Per M. Daniels on 6/24/2021 by L.J.

STDI2. The hospital has been designated as a**disproportionate share hospital** under the state Medicaid program in the period covered by this report (2020) or in either of its two previous fiscal years. Completion of section I-3. or I-4. is not required.

I-2
[ ]

I3. STANDARDS - Please check the appopriate box (A, B, or C) below and provide the requested information.

A. Charity care and government-sponsored indigent health care are provided at a level which is reasonable in relation to the community needs, as determined through the community needs assessment, the available resources of the hospital, and the tax-exempt benefits received by the hospital.

A.[ ]

		Hospital
STDI3A1.	Tax exempt benefits (Worksheet 5)	
STDI3A2.	Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year	

B. Charity care and government-sponsored indigent health care are provided in an amount equal to at least 100 percent of the hospital's tax-exempt benefits, excluding federal income tax. (Standard B is met if B.4. is greater than or equal to B.3.)

[ ] B.

		Hospital	System
STDI3B1.	Tax-exempt benefits (Worksheet 5)		
STDI3B2.	Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year		
STDI3B3.	Total of B.1. and B.2. above		
STDI3B4.	Enter the total from item II.C		

C. Charity care and community benefits are provided in a combined amount equal to at least five (5) percent of the hospital s net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four (4) percent of net patient revenue. (Standard C is met if C.4. is greater than or equal to C.3. and C.8. is greater than or equal to C.7.)

C.[]

Per A. Orbach on 7/2/2021 by L.J.

	Hospital	System
STDI3C1. Multiply Net Patient Revenue (I-1.) by 5%	2,759,465	
STDI3C2. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year		
STDI3C3. Total of C.1. and C.2. above	2,759,465	
STDI3C4. Enter the amount recorded in item II.E.	**7,195,067**	
STDI3C5. Multiply Net Patient revenue (I-1.) by 4%	2,207,572	
STDI3C6. Shortfall in charity care and government-sponsored indigent health care from the prior fiscal year		
STDI3C7. Total of C.5. and C.6. above	2,207,572	
STDI3C8. Enter the amount recorded in item II.C.	**918,647**	

Per A. Orbach on 7/2/2021 by L.J.

I4. Check this box if your hospital **did not meet** any of the standards in sections I-3. Please attach explanatory information.

[X] I-4

I5. Certification Contact Information - Annual Statement of Community Benefits
*

Coordinator Name	Coordinator Title	Phone	Fax	Electronic/internet Mail address
Melanie Pipes	CFO	(806) 725-4000	(806) 788-4235	mpipes@gracehealthsystem.com

If you're reporting as a system, please provide system aggregate data

****

Texas Nonprofit Hospitals*
Part II

Summary of Current Charity Care Policy and Community Benefits for Inclusion in DHSH Charity Care Manual as Required by Texas Health and Safety Code, 311.0461** 2020

Name of Hospital:	Grace Medical Center
County:	Lubbock
Mailing Address:	7509 Marsha Sharp Freeway
Physical Address if different from above:	_____
Effective Date of the current policy:	12/05/2020 (mm/dd/yyyy)
Date of Scheduled Revision of this policy:	12/05/2021 (mm/dd/yyyy)
How often do you revise your charity care policy?	yearly

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

Name of the office/department:	Patient Finiancial Services
Mailing Address:	2107 Oxford Avenue, Suite 200
Contact Person:	Gena Pittman
Title:	PFS Manager
Phone:	(806) 725-7196
Fax:	(806) 723-6180
E-Mail: *	georgena.pittman@providence.org

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 also available in PDF format at DSHS web site: www.dshs.state.tx.us/chs/hosp under 2020 Annual Statement of Community Benefits Standard.

This information will be made available for public use. Please report most current information on the charity care policy and community benefits provided by the hospital.

I. Charity Care Policy:

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

Grace Medical Center as part of SJH is a not-for-profit healthcare organization guided by a commitment to its Mission of serving all, especially those who are poor and vulnerable, by its Core Values of compassion, dignity, justice, excellence and integrity, and by the belief that healthcare is a human right. It is the philosophy and practice of each SJH hospital that emergent and medically necessary healthcare services are readily available to those in the communities we serve, regardless of their ability to pay.

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

a. Provide the definition of **charity care** for your hospital.	
Grace Medical Center as part of SJH will provide free or discounted hospital services to qualified low income, uninsured and underinsured patients when the ability to pay for services is a barrier to accessing medically necessary emergency and other hospital care and no alternative source of coverage has been identified. Patients must meet the eligibility requirements described in this policy to qualify. SJH hospitals with dedicated emergency departments will provide, without discrimination, care for emergency medical conditions (within the meaning of the Emergency Medical Treatment and Labor Act) consistent with available capabilities, regardless of whether an individual is eligible for financial assistance. SJH will not discriminate on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law when making financial assistance determinations. SJH hospitals will provide emergency medical screening examinations and stabilizing treatment, or refer and transfer an individual if such transfer is appropriate in accordance with 42 C.F.R 482.55. SJH prohibits any actions, admission practices, or policies that would discourage individuals from seeking emergency medical care, such as permitting debt collection activities that interfere with the provision of emergency medical care.	

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

( ) Less then 100 %
( ) Less then 133 %
( ) Less then 150 %
( ) Less then 200 %
(x) Other, specify ≤175

c. Is eligibility based upon net or gross income?

( ) Net
(x) Gross

d. Does your hospital have a charity care policy for the Medically indigent?

(x) Yes ( ) No

If yes, provide the definition of the term **Medically Indigent**.

The patient is determined to be medically indigent if Annual gross income is between 176% and 300% of the current FPL guidelines. The reimbursement for services or patient responsibility shall not exceed the AGB on each inpatient account. Reimbursement for services on Outpatient accounts shall be determined by using the SJH Calculator for Financial Assistance for Texas Hospitals. A patients responsibility in these circumstances shall not exceed the AGB

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

( ) Yes (x) 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
[x] 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.

[x] 1. Wages and salaries before deductions
[x] 2. Self-employment income
[x] 3. Social security benefits
[x] 4. Pensions and retirement benefits
[x] 5. Unemployment compensation
[ ] 6. Strike benefits from union funds
[ ] 7. Worker's compensation
[ ] 8. Veteran's payments
[x] 9. Public assistance payments
[ ] 10. Training stipends
[x] 11. Alimony
[x] 12. Child support
[ ] 13. Military family allotments
[x] 14. Income from dividends, interest, rents, royalties
[ ] 15. Regular insurance or annuity payments
[x] 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?

(x) Yes ( ) No

If Yes:

a. **Please send a copy of the charity care application form.**

b. How does a patient request an application form? Check all that apply.

[x] 1. By telephone
[x] 2. In person
[x] 3. Other, please specify: Online https://www.covenanthealth.org/

c. Are charity care application forms available in places other than the hospital? *

( ) Yes (x) No *

If Yes, please provide the name and address of the place:

Name: _____

Address: _____

d. Is the application form available in language(s) other than English? *

(x) Yes ( ) No *

If yes, please check:

[x] Spanish
[x] Other please specify: German

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
(x) 3. The hospital uses both independent verification and patient self-declaration

b. What documents does your hospital use/require to verify income, expenses, and assets? Check all that apply.

[x] 1. W2-form
[x] 2. Wage and earning statement
[x] 3. Pay check remittance
[x] 4. Worker's compensation
[x] 5. Unemployment compensation determination letters
[x] 6. Income tax returns
[x] 7. Statement from employer
[x] 8. Social security statement of earnings
[x] 9. Bank statements
[x] 10. Copy of checks
[x] 11. Living expenses
[ ] 12. Long term notes
[ ] 13. Copy of bills
[ ] 14. Mortgage statements
[ ] 15. Document of assets
[x] 16. Documents of sources of income
[ ] 17. Telephone verification of gross income with the employer
[ ] 18. Proof of participation in govt 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 time of admission
[ ] b. During hospital stay
[ ] c. At discharge
[x] d. After discharge

[ ] e. Other, please specify _____

6. How much of the bill will your hospital cover under the charity care policy? Check all that apply.

[ ] a. 100%
[x] 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 (x) No

8. How many days does it take for your hospital to complete the eligibility determination process?

3-5 days

9. How long does the eligibility last before the patient will need to reapply?

(x) 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.

[x] a. In person
[x] b. By telephone
[x] c. By correspondence
[ ] d. Other, specify _____

11. Are all services provided by your hospital available to charity care patients?

(x) 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 (x) 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). If more space is needed, please send additional information in a Word or PDF file. *

N/A

Additional Information:

_____

***Please take a brief second to fill out the SIX question feedback survey in the link below.**

CLICK HERE