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**
2017

Facility Identification (FID): 3396327 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: CHI St. Luke's Health The Woodlands Hospital **County:** Montgomery

Mailing Address: 17200 St. Luke's Way, The Woodlands Tx 77384

Physical Address if different from above:

Effective Date of the current policy: 09/01/2016

Date of Scheduled Revision of this policy: 09/01/2019

How often do you revise your charity care policy? 3 years

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: 17200 St. Luke's Way, The Woodlands Tx 77384

Contact Person: Mike Praetorius Title: Director

Phone: (936) 266-9613 Fax: E-Mail mpraetorius@stlukeshealth.org

Person completing this form if different from above:

Name: Eric Ransom Phone: (936) 266-4058

*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 2017 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.

Patient Financial Assistance Program (PFAP). The Hospital will provide partial or full financial assistance for medically necessary care in accordance with Texas law and hospital eligibility guidelines to patients who require hospital care or medical services, and cannot afford such care or services because of limitations in their health insurance or personal finances. Financial assistance is determined without regard to race, gender, religion, creed or national origin. The program strives to balance a patient¿s need for financial assistance with the Hospital¿s broader fiscal responsibilities. Financial assistance is not a substitute for personal responsibility and all patients are expected to contribute to the cost of their care based upon their individual ability to pay, including assisting the Hospital in applying for governmental or other funding for which the patient might be eligible. Further, patients discharged from the Emergency Department who qualify as financially indigent will be expected to pay a nominal amount of $100.00 per visit toward the services they received. The hospital will post notices in conspicuous areas that provide information on financial assistance to low-income patients, with instructions on how to apply for PFAP.

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

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

Providing, funding or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the Hospital as ¿financially indigent¿ or ¿medically indigent¿, or providing funding or otherwise financially supporting health care services provided to indigent persons through other non-profit or public outpatient clinics, hospitals or health care organizations.

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**.

An uninsured or underinsured person whose catastrophic illness or injury results in a hospital balance (after payment by third-party payers) that exceeds a specified percentage of the annual gross income, with the person financially unable to pay the balance.

e. Does your hospital use an Assets test to determine eligibility for charity care?
☑ YES NO If yes, please briefly summarize method. In determining whether the patient meets the criteria for charity care, the hospital may consider the extent to which a person has assets other than income that could be used to meet his or her obligations. To assist in this determination, a financial sta

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 _____

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 _____

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?

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).

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).

Violence prevention Serving the indigent Chronic care management

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 sixteenth 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: