`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): 3032377 (Enter 7-digit FID# from attached hospital listing)***

Name of Hospital: Grace Surgical Hospital **County:** Lubbock

Mailing Address: 7509 Marsha Sharp Freeway, Lubbock TX 79407

Physical Address if different from above:

Effective Date of the current policy: 01/01/2018

Date of Scheduled Revision of this policy:

How often do you revise your charity care policy? as necessary

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

Name of the office/department: Providence Health System

Mailing Address: 315 SE Stonemill Drive, Vancouver, WA 98682

Contact Person: Anthony Valdez Title: Director Financial Counseling Operations

Phone: (503) 446-2548 Fax: (503) 789-4156

Person completing this form if different from above:

Name: Vanessa Reasoner Phone: (806) 725-4000

* 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.

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

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? Check one.
5

1. 100%
2. <133%
3. <150%
4. <200%
☑ 5. Other, specify Less than 175%

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**.

PSJH will provide medically necessary health care services to members of the community who are unable to pay for such services. The determination of financial assistance will be based on the patient's ability to pay consistent with eligibility criteria established by PSJH. Charity care does not include bad debt or contractual shortfalls from government programs, but may include insurance co-payments, deductibles or both. As part of this commitment, PSJH shall provide a discount to uninsured patients for medically necessary services.

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 on line; 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.

on line; via email,

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

☑ YES NO

If yes, please check

Spanish ☑ 1 Other, please specify many

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 _____

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? 7

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).

dental; diabetes

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: