TEXAS CHILDREN'S HOSPITAL **POLICY & PROCEDURE**

MANUAL:	TCH	POLICY NO:	GA303-01
SECTION:	General and Administrative	PROC. NO:	GA303-01
TITLE:	FINANCIAL ASSISTANCE/ CHARITY CARE POLICY	ORIG. DATE:	01/05/89
RESP:	Administration	EFF. DATE:	05/14/10
REV. BY:		DISTRIBUTION:	All Departments

POLICY STATEMENT -01

Texas Children's Hospital ("TCH" or "Hospital") is committed to providing the highest quality care and recognizes that some of its patients and/or patient families are unable to pay for some or all of their care. It is the policy of TCH to provide financial assistance to patients who are financially or medically indigent in furtherance of the mission and values of the Hospital.

This policy sets forth the standards and processes by which TCH provides free or discounted care to patients who are financially or medically indigent. Financial assistance will be available to all patients who qualify. Charity Care is only applicable to services deemed "medically necessary" by Medicare, Medicaid, or industry standards. Other services not deemed "medically necessary" must be pre-qualified by the Charity Care Committee.

Financial assistance from TCH is considered as a "last resort" and is based upon patients meeting eligibility requirements. The Hospital will identify eligible patients and determine the amount of financial assistance available in connection with the Hospital's available resources, need to maintain financial stability and desire to continue to provide the highest quality care to its patients.

No patient will be denied financial assistance because of his or her race, religion, or national origin or any other basis which is prohibited by law. In implementing this policy, Texas Children's will comply with all applicable federal, state and local laws, rules and regulations.

DEFINITIONS -01

1. **Bad Debt**: Hospital charges that a patient is able but unwilling to pay or refuses to pay.

2. **Charges**: For purposes of this policy only (per the Patient Protection and Accountability Act), hospital charges that are generally billed to individuals who have insurance coverage covering such care.

3. **Charity Care**: Includes the following: (1) the unreimbursed cost to the Hospital for services provided to a patient receiving inpatient and/or outpatient treatment who meets the Hospital's criteria of financially or medically indigent, and/or (2) the cost to the Hospital for services provided to an uninsured patient who does not have the ability to pay.

4. **Charity Care Committee:** A Hospital committee comprised of appropriate representatives from the Hospital and/or Medical Staff with responsibility for: 1) annual review and if appropriate update of Charity Care eligibility policies and 2) review of applications for Charity Care and approving or denying Charity Care assistance.

5. **Charity Care Deductible**: The portion of a charity patient's Hospital bill that is the patient's responsibility. This amount may be determined by a Financial Counselor, a Patient Account Representative or the Charity Care Committee, as set forth in this policy.

6. **Family Income or Gross Income:** Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance payments, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Family Income is based on definitions used by U.S. Bureau of the Census.

7. **Federal Poverty Guidelines ("FPG")**: Guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services.

8. **Financial Assistance**: Hospital care provided at a discounted rate. A patient who is uninsured for the relevant service and who is not eligible for coverage through a Government Healthcare Program or other insurance, and who has family income in excess of 200% but less than 400% of FPG, will be eligible to receive Financial Assistance in the form of a discount off charges.

9. **Financially Indigent**: A patient who the Hospital has determined is unable to pay some or all of the patient's Hospital bills due to the patient's and/or the patient's family's income being below specified thresholds based on the FPG and/or because their monetary assets are below specified thresholds.

10. **Government Healthcare Program**: Any healthcare program operated or financed at least in part by the federal, state or local government (includes but is not limited to Medicare, Medicaid, and CHIP).

11. **Medically Indigent**: A patient who the Hospital has determined to be unable to pay some or all of his or her Hospital bills because such bills exceed a certain percentage of the patient's or patient's family's income and/or assets (e.g. due to catastrophic cost or other conditions), even though the patient and/or family have income or assets that disqualify them from meeting the criteria for financially indigent.

12. **Service Area**: Includes the following counties: Harris, Brazoria, Chambers, Fort Bend, Galveston, Liberty, Montgomery, and Waller.

13. **Under-insured Patient:** A patient who has some insurance or third-party coverage but has out-of-pocket expenses (self-pay balances) that exceed the patient's ability to pay.

14. **Uninsured Self-Pay Patient**: A patient who has no insurance or third party coverage to assist with meeting the patient's payment obligations.

PROCEDURE -01

1.0 **OVERVIEW**

1.01 The Patient Financial Services Department will identify patients who may be eligible for Financial Assistance.

1.02 A patient requiring Financial Assistance or Charity Care or thought to require such assistance will be referred to a Financial Counselor or Financial Assistance Specialist.

1.03 A patient seeking Financial Assistance or Charity Care must complete an application with a Financial Counselor. An application will be made available to anyone requesting one.

1.04 A patient is only eligible for Charity Care after all other financial resources available to the patient have been exhausted and the patient and patient's family are without sufficient income to cover out of pocket expenses, as determined by TCH. Existing and potential financial resources for the patient, such as, but not limited to, private health insurance, CHIP, agency funding, Medicare and/or Medicaid, will be reviewed.

1.05 Charity Care is only applicable to services deemed "medically necessary" by Medicare, Medicaid, or industry standards. In instances where medical necessity is unclear, the Charity Care Committee will follow up with the patient's physician.

2.0 ELIGIBILITY

2.01 Eligibility is based upon Citizenship (US Citizen) and Residency (Service Area). Patients who are U.S. citizens and live in the Service Area are eligible for Charity Care per this policy.

2.02 Charity Care discount percentages are calculated using FPG, and may be updated in conjunction with FPG updates published in the Federal Register.

2.03 If a patient's annual family income is 100% or below of the FPG, the patient will most likely qualify for Medicaid. If the income is 101-200% of the FPG, or the patient does not qualify for Medicaid, the patient may qualify for CHIP. If the patient does not qualify for Medicaid, CHIP or any other program and the family income is below 400% of the FPG, the guidelines in Exhibit A will be applied to calculate the percentage of Financial Assistance to which the patient is entitled, and what the Charity Care Deductible will be.

2.04 If a patient has Medicare but no secondary coverage and income is within the FPG contained in this policy, the patient is required to apply for Medicaid prior to being considered for Charity Care.

2.05 A patient who is not a legal U.S. resident or resides outside of TCH's Service Area may be considered Financially Indigent or Medically Indigent under appropriate circumstances. Any Financial Assistance must be approved by the Charity Care Committee, taking into account the nature of the child's illness, the likelihood that treatment will lead to a successful outcome, the disposition of similar cases involving children who are legal U.S. residents, and the budgetary constraints of the Hospital.

2.06 In addition to using the FPG to determine a patient's eligibility for Financial Assistance, the following factors will be considered:

1. Family Income. Gross income generally must fall within FPG with consideration to family size, geographic area, and other relevant factors.
2. Denials. A patient must have applied for and been denied medical coverage by all potential funding sources including, but not limited to: Medicaid, Special HealthCare Needs (CSHCN), CHIP, Medicare (if applicable), and/or any potential commercial program.
3. Employment Status
4. Current Financial Obligations
5. Good Faith. Patients are expected to cooperate with the application process. If the application is denied for reasons other than an incomplete application, the patient's application will be presented to Charity Care Committee for consideration.

3.0 ELIGIBILITY DETERMINATION

3.01 Financial Counselors and Patient Account Representatives may determine the appropriate amount of Financial Assistance available to patients, and the amount of any applicable Charity Care Deductible in relation to the amount due after applying all other resources. The manager of the Financial Counselor or Patient Account Representative may approve the request for Charity Care in accordance with the FPG. All other applications must be forwarded to the Charity Care Committee.

3.02 A patient who can afford to pay for a portion of the services provided by the Hospital is expected to do so, even if the patient is Medically Indigent. The patient's portion of the Hospital bill will be described as the patient's Charity Care Deductible. Patients who have a Charity Care Deductible will be required to pay the deductible.

3.03 A determination of eligibility for Charity Care is effective for six (6) months and is applicable toward all Hospital balances incurred prior to an approved Charity Care application.

3.04 If a Charity Care application is approved, Charity Care will apply to balances after all third party coverage has been collected. Whenever other funding is available, whether or not the patient has been approved for Charity Care, agency funding must be secured prior to the service being scheduled and covered by Charity Care.

3.05 The Charity Care Committee may change a previous decision regarding a patient's eligibility for Financial Assistance based on a case by case basis.

3.06 A patient's eligibility for Financial Assistance may be reevaluated when one or more of the following occur:

1. Subsequent rendering of services
2. Income change
3. Family size change
4. When any part of the patient's account is Bad Debt or is in collections
5. Six months has elapsed since the patient qualified for Financial Assistance

4 AMOUNTS CHARGED TO PATIENT

4.01 TCH uses a "sliding scale" to determine the percentage discount applicable to a patient who qualifies for Financial Assistance. See Exhibit A.

4.02 If a patient/family is not eligible to participate in a Government Healthcare Program, TCH offers the following financial assistance to Uninsured Self-Pay Patients:

1. With Gross Income between 0% and 200% of the FPG, there is a 100% discount off billed charges.
2. With Gross Income between 201% and 300% of the FPG, there is a 75% discount off billed charges.
3. With Gross Income between 301% and 400% of the FPG, there is a 50% discount off billed charges
4. With Gross Income greater than 400% + of the FPG or those families who refuse to complete a Financial Assistance Application (Charity Care Application), there is a self-pay or prompt-pay discount of 40% of Charges.

4.03 A Medically Indigent patient is expected to pay a portion of the patient's Hospital bill. This portion is referred to as the Charity Care Deductible. Any portion of a Hospital bill that is not paid by a third party that is in excess of the Charity Care Deductible may be considered Charity Care by the Hospital. There may be occasions when a patient/family has experienced a catastrophic illness and cannot afford to pay the entire Charity Care Deductible. A payment plan (not to exceed 6 months) may be approved by the Patient Financial Services Department.

4.04 A Medically Indigent patient must meet his/her Charity Care Deductible and be re-evaluated at least every six (6) months in order to continue receiving Financial Assistance.

4.05 If a patient/family has out-of-pocket expenses, separate and apart from the patient's Hospital bills, that total more than 25% of the patient's/family's annual gross income, TCH will work with the patient/family on a payment plan so they will not be required to pay more than 25% of their gross income in any one year.

5 Application for Charity Care

5.01 An application may be completed by anyone who requests it or is identified with a need. An sample application is attached as Exhibit B. Any TCH employee or physician may refer a patient to the Financial Counselor/Patient Account Representative or Patient Accounting to initiate a Charity Care application. Charity Care may be granted at any stage of the Hospital's revenue cycle.

5.02 If the payment falls within the FPG, the Manager of Patient Admissions may approve the request for Charity Care if the patient resides in the Service Area and the family meets all other requirements. All other applications must be forwarded to the Charity Care Committee.

5.03 Patient Accounting will provide a written decision regarding a patient's eligibility for Charity Care to the applicant within 30 days of receipt of a completed application. This notification will include the discount amount approved, the payment that is expected from the patient, and reasons for any denial (if the request is denied).

5.04 If a patient does not have Medicaid or other private agency funding, but may qualify, the patient must cooperate with the application process to be considered for Charity Care. If a patient does not cooperate with the application process, Charity Care will be denied or revoked if active approval is on file and the patient will be responsible for any balances. The patient is required to provide the following documentation, at a minimum: any evidence of third party coverage, employment status, verification of employment and income, proof of residency, and family size. Verification of Income may include one or more of the following:

1. Prior Year Tax Returns;
2. Current Pay Stubs (last 2 months) or written verification of wages from Employer;
3. Social Security Check;
4. Bank Statement;
5. Disability check

5.05 A patient who does not provide the requested information or does not cooperate with efforts to secure coverage from a Governmental Healthcare Program will not be eligible for Charity Care or Financial Assistance. Such cooperation is not a precondition to the receipt of medically necessary treatment or emergency care.

5.06 Denials may be appealed through the Patient Financial Services department. Appeals should include supporting documents that demonstrate inability to pay that were not available or included at the time of the initial consideration.

5.07 Patient Accounting will retain all records relating to Charity Care for seven years.

6 Non-payment

6.01 If a patient does not pay the Charity Care Deductible for and fails to renegotiate a payment plan (if applicable), the uncollected balance will be considered Bad Debt.

6.02 The Hospital may use any and all reasonable efforts to collect Bad Debt. These efforts may include but are not limited to 1) telephone calls 2) email correspondence and 3) written correspondence.

7 Publication

In accordance with law, TCH will post information regarding the availability of Financial Assistance and Charity Care, and the existence of this policy. Information and instructions for applying for Financial Assistance and Charity Care will be posted in key public areas throughout the Hospital where patients present for services. Information is also provided in patient welcome packets. This policy will be available in Spanish, a notice regarding this policy will be published annually in the local paper, and a link to this policy will be available on the Hospital's website.

8 Exceptions

Extenuating circumstances may arise in determining eligibility for patients who do not meet established criteria. The Charity Care Committee is charged with reviewing and approving such cases.

ASSOCIATED DOCUMENTS

EXHIBIT A – 2010 Federal Poverty Guidelines
EXHIBIT B – Charity Care Application

ASSOCIATED LAWS AND REGULATIONS

TEXAS HEALTH AND SAFETY CODE ANN. §§ 311.031 - 311.048
TEXAS TAX CODE § 153.310, § 171.063
Medicaid Conditions of Participation

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Review Dates:		**Revision/Approval Dates:**	
Administrative Policy & Procedure Operations Committee	05/12/10	Senior Vice President, HR	05/13/10

EXHIBIT A: 2010 FEDERAL POVERTY GUIDELINES

Size of family unit	100 Percent of Poverty	110 Percent of Poverty	125 Percent of Poverty	150 Percent of Poverty	175 Percent of Poverty	185 Percent of Poverty	200 Percent of Poverty
1	$10,830	$11,913	$13,538	$16,245	$18,953	$20,036	$21,660
2	$14,570	$16,027	$18,213	$21,855	$25,498	$26,955	$29,140
3	$18,310	$20,141	$22,888	$27,465	$32,043	$33,874	$36,620
4	$22,050	$24,255	$27,563	$33,075	$38,588	$40,793	$44,100
5	$25,790	$28,369	$32,238	$38,685	$45,133	$47,712	$51,580
6	$29,530	$32,483	$36,913	$44,295	$51,678	$54,631	$59,060
7	$33,270	$36,597	$41,588	$49,905	$58,223	$61,550	$66,540
8	$37,010	$40,711	$46,263	$55,515	$64,768	$68,469	$74,020

EXHIBIT B: CHARITY CARE APPLICATION

Texas Children's Hospital
Request for Uncompensated Services

As provided by Federal law, I/we ask Texas Children's Hospital to determine if I/we are eligible for help in paying for our child's bill. I/we understand that I/we need to give certain information for this to be done. I/we also understand that Texas Children's Hospital or its agents will check these facts for accuracy. I/we understand that filling out this form does not guarantee that I/we will receive this help. If I am (we are) not eligible for uncompensated services, I am (we are) responsible for my child's hospital bill.

Patient's Name: _____ **Visit Number:** _____
(First) (Middle) (Last)

Address: _____ (Street) _____ (City/State) _____ (Zip)

Home Phone: (_____ **)** _____ - _____ **SSN:** _____-_____-_____

DOB: __/ __ / __ **Place of Birth:**_____ **Gender:** M or F **Religion:** _____

Ethnicity: White – Black – Hispanic – Asian – Asian/Pacific Islander
Other: _____

Is the patient a U.S. Citizen? Yes or No **Is the patient a legal U.S. Resident?** Yes or No

Mother's Name: _____ / _____ **DOB:** ____/ _____/_____
(First) (Middle) (Last) (Maiden Name)

Address:

_____
(Street) (City/State) (Zip)

Home Phone: (_____ **)** _____ - _____ **SSN:** _____-_____-_____

Employer Name: _____ **Work Phone: (** _____ **)** _____ _____

Employer Address:

_____
(Street) (City/State) (Zip)

Father's Name: _____/_____**DOB:**____/_____/_____
(First) (Middle) (Last) (Maiden Name)

Address:

_____
(Street) (City/State) (Zip)

Home Phone: (_____ **)** _____ - _____ **SSN:** _____-_____-_____

Employer Name: _____ **Work Phone: (** _____**)** _____ _____

Employer Address:

_____
(Street) (City/State) (Zip)

If yes, when? _____ **Previous Patient?** Yes or No

Potential Third Party Payor Source (please circle one):

Private Insurance Medicaid/Medicaid HMO Medicare CHIP CSHCN
Other _____

Physician's Name: _____ Diagnosis:

Number of Family Members living in household:			**Please list all family members:**
Name	Relationship	Age	Gender
1.			
2.			
3.			
4.			
5.			
6.			
7.			

INCOME: Must Provide Photocopies of Check Stubs and Last Two (2) Monthly Bank Statements

	Gross Income/Monthly
Wages (self)	
(Spouse)	
(Other family members)	
Farm or Self-Employment	
Public Assistance Social Security Unemployment Compensation	
Alimony	_____
Child Support	_____
Military Family Allotments	_____
Pensions	
Income from Dividends, Interest, Rental Property	
Trust Fund(s)	
Other Income (Retirement/Disability, etc)	_____

TOTAL INCOME _____ _____ **/ Monthly**

EXPENSES

Mortgage/Rent _____ - If none, what is the source of housing?_____
Auto Loans _____ Utilities _____ Food
Loans_____Credit Cards _____ Alimony/Child Support _____
Medical Insurance_____
Auto Insurance _____ Medical Bills_____
Medications _____
Other

TOTAL EXPENSES: _____ / Monthly

Do you own a home? Yes or No - If yes, estimated value $ _____Amount Owed $

Do you own other property? Yes or No - If yes, estimated value $ _____

Automobiles: Model/Make _____Year_____ Value $ ____

- I/we declare under penalty of perjury that the answers I/we have given are true and correct to the best of my/our knowledge.
- I/we agree to tell the provider of services, within 10 days, if there are any changes in my (or the persons on whose behalf I am (we are acting) income, property, expenses, or in the person in the household or of any change of addresses.
- I/we understand that I/we may be asked to prove my statements and that my/our eligibility statements will be subject to verification by contact with my employer, bank, credit verification, and property searches.
- I/we understand that the county, hospital and home health are required by law to keep any information I/we provide confidential.
- I/we further agree, that in consideration for receiving health care services as a result of an accident or injury, to reimburse the county, hospital or home health from proceeds of any litigation or settlement resulting from such act.
- I/we understand that if I/we do not qualify for uncompensated services, I/we will be personally liable for the charges of the services rendered by Texas Children's Hospital or Home Health Services or I/we may appeal decision in writing with additional documentation.

Signature of Mother/Guarantor: _____ Date:

Signature of Father/Guarantor: _____ Date: