

# **EAST TEXAS MEDICAL CENTER REGIONAL HEALTHCARE SYSTEM CHARITY CARE & UNINSURED PATIENT POLICY**

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## **I. POLICY**

By virtue of their exemption from federal and state taxes and as a part of their mission to serve the health care needs of their communities, each hospital within the East Texas Medical Center Regional Healthcare System (System) will provide charity care to patients who meet the criteria of this policy and do not have the financial means to pay for hospital services.

Charity care will be provided to patients who present themselves for care at a System hospital without regard to age, sex, race, creed, color, or national origin and who are classified as financially indigent or medically indigent according to the terms of this policy.

Each hospital within the System reserves the right to limit charity care on a monthly and annual basis consistent with Texas state law and the hospital's financial resources. Each hospital reserves the right to refuse charity care for elective care.

A discount from the hospital's retail charges will be made available to uninsured patients who do not qualify for charity care, under the terms of this policy.

## **II. DEFINITIONS**

- a. Bad Debt Charges resulting from treatment for services provided to a patient and/or guarantor who, having the requisite financial resources to pay for health care services, has demonstrated by his/her actions an unwillingness to comply with the contractual arrangements to resolve a bill or satisfy their outstanding obligations.
- b. Charity Care Inpatient and outpatient medical treatment and diagnostic services for uninsured or underinsured patients who cannot afford to pay for the care according to the guidelines of this Policy. Charity Care does not include bad debt or contractual allowances from government programs and insurance, or Uninsured Patient Discounts, but may include insurance co-payments or deductibles, or both. The patient will have no obligation, or a discounted obligation, to pay for any services received which are deemed to be Charity Care under this Policy.
- c. Contractual Allowance The difference between the level of payment established under a contractual agreement and the patient's billable charges.
- d. Elective Care The patient's condition permits time for medical services to be scheduled.

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- e. Emergency Care The patient requires immediate medical intervention due to a severe, life-threatening, or potentially disabling condition. Generally the patient is admitted through the emergency room.
- f. Patient The terms “patient” and “person” are used throughout this Policy for ease of understanding and drafting. This Policy applies to the guarantor of the patient’s account, and the term guarantor is interchangeable with the terms patient and person throughout this Policy, when the guarantor is different from the Patient.
- g. Retail Charges The standard rates charged to all patients, which do not reflect any contractual allowances or discounts. These rates are commonly referred to as “gross” charges in the healthcare industry.
- h. Uninsured Patient A person receiving healthcare services who does not have private healthcare insurance, and is not qualified to participate in a governmental program which provides healthcare benefits to its eligible participants (such as Medicare or Medicaid), and for purposes of this Policy does not qualify for Charity Care.
- i. Uninsured Patient Discount The amount of discount applied to Retail Charges incurred by Uninsured Patients.
- j. Urgent Care The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.

### **III. CHARITY CARE ELIGIBILITY CRITERIA**

#### **A. Financially Indigent**

- a. A financially indigent patient is a person who is uninsured or underinsured and whose bill will result in no obligation or a discounted obligation to pay for the services rendered based on the eligibility criteria set forth in this policy.
- b. To be eligible for charity care as a financially indigent patient, a person’s income shall be at or below the percentage of the federal poverty guidelines noted at Exhibit A. The hospital may consider other financial means of the person when determining eligibility.
- c. The hospital will use the most current poverty income guidelines issued by the U.S. Department of Health and Human Services to determine an individual’s eligibility for charity care as a financially indigent patient. The poverty income guidelines are published in the Federal Register in the Spring of each year and for purposes of this policy will become effective the first day of the month following the month of publication.

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- d. The System may adjust the eligibility criteria from time to time based on financial resources and as necessary to meet the charity care needs of each community. The System may limit charity care to only those patients requiring emergency or urgent care.
- e. Patients with a current Texas Medicaid card will be considered to be financially indigent with regard to any unpaid balances.

### **B. Medically Indigent**

- a. A medically indigent patient is a person whose unpaid hospital charges exceed their ability to pay and whose remaining bill will result in no obligation or a discounted obligation to pay for the services rendered, based on the eligibility criteria set forth in this policy.
- b. To be eligible for charity care as a medically indigent patient, the amount owed by the patient on the hospital bill after payment by third-party payers, if applicable, must exceed the percentage of the patient's annual gross income noted at Exhibit B, and the patient must be unable to pay the remaining bill. The hospital may consider other financial means of the person when determining ability to pay.
- c. Charity care for the medically indigent may be provided in an amount that is less than the patient liability.
- d. The System may adjust the eligibility criteria from time to time based on financial resources and as necessary to meet the charity care needs of each community. The System may limit charity care to only those patients requiring emergency or urgent care.

### **IV. UNINSURED PATIENT DISCOUNT ELIGIBILITY CRITERIA**

An uninsured patient who does not qualify as financially or medically indigent shall receive a discount according to Exhibit C. Some System hospitals operate physician clinics, and/or provide physician or other health professional services as part of their operations. For those hospitals offering such physician or health professional services, this discount does not apply to their professional fees, or charges for other hospital services rendered which are associated with the services provided by a physician or other health professional. Additionally, the discount does not apply to air or ground ambulance services. System hospitals may also exclude other charges from receiving an uninsured patient discount, as they deem appropriate.

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## **V. PROCEDURE**

### **A. Identification of Charity Cases**

- a. Hospitals will inform each patient of the charity care program and how to apply for charity care. This will be done by posting notices in each patient registration area and providing a written notice to each patient. An additional notification shall be provided on the System's web-site.
- b. The Business Office will attempt to identify all cases that may qualify as charity at the time of admission, and ask the patient to apply at that time.
- c. Patients who desire to apply for charity care shall complete a Financial Assistance Application form (Exhibit D) and return it to the specific address so noted.
- d. The Business Office will refer those patients who may qualify for financial assistance from a governmental program to the appropriate program, such as Medicaid.
- e. As soon as sufficient information is available concerning the patient's financial resources and status of eligibility for governmental assistance, a determination will be made concerning the patient's eligibility for charity.

### **B. Charity Determination Process**

All charity applications will be forwarded to the Community Benefits Department where they will be evaluated according to established charity care application processing procedures. The Community Benefits Department will determine if the application qualifies for charity care.

### **C. Recordkeeping and Reporting of Charity Care**

- a. All completed charity care applications and supporting documentation will be retained and kept on file for five (5) years in the Community Benefits Department.
- b. Information regarding the amount of charity care provided by the hospital in its' fiscal year shall be aggregated and included in the hospital's annual report filed with the Bureau of State Health Data and Policy analysis at the Texas Department of State Health Services. This report also will include information concerning the provision of government-sponsored indigent health care and other community benefits.

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## **D. Uninsured Patient Discount**

An uninsured patient discount will be applied to all uninsured patients who do not apply for, or do not meet the criteria of, the requirements for receiving charity care, subject to the provisions of Section IV. The amount of the discount is noted at Exhibit C, and may be changed by the System from time to time.

East Texas Medical Center Regional Healthcare System  
 Charity Care & Uninsured Patient Policy  
 Financially Indigent

Exhibit A

2011 Federal Poverty Guidelines		Charity Qualification Limits
Size of Family Unit	Maximum Family Income	(200% of FPG*) If Income Does Not Exceed **
1	\$ 10,890	\$ 21,780
2	14,710	29,420
3	18,530	37,060
4	22,350	44,700
5	26,170	52,340
6	29,990	59,980
7	33,810	67,620
8	37,630	75,260
ea. Add'l Person	3,820	7,640

\* FPG (Federal Poverty Guidelines)

\*\* In addition to meeting the income guidelines, a person's other financial means may be considered in the charity care determination process.

East Texas Medical Center Regional Healthcare System  
 Charity Care & Uninsured Patient Policy  
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Exhibit B

2011 Federal Poverty Guidelines		Maximum Income Levels**			Minimum Unpaid Hospital Charges		
Size of Family Unit	Maximum Family Income	250% FPG*	300% FPG*	>300% FPG*	250% FPG*	300% FPG*	>300% FPG*
1	\$ 10,890	\$ 27,225	\$ 32,670	\$> 32,670	\$ 2,723	\$ 3,267	10% of
2	14,710	36,775	44,130	> 44,130	3,678	4,413	actual
3	18,530	46,325	55,590	> 55,590	4,633	5,559	annual
4	22,350	55,875	67,050	> 67,050	5,588	6,705	income
5	26,170	65,425	78,510	> 78,510	6,543	7,851	"
6	29,990	74,975	89,970	> 89,970	7,498	8,997	"
7	33,810	84,525	101,430	> 101,430	8,453	10,143	"
8	37,630	94,075	112,890	> 112,890	9,408	11,289	"
ea. Add'l Person	3,820	9,550	11,460	> 11,460	955	1,146	"
Unpaid charges as % of income					10%	10%	10%
Amount of each monthly payment					\$ 40	\$ 50	\$ 60
Number of months payments are due					24 mo's.	24 mo's.	24 mo's.

Explanation:

A person is Medically Indigent if their unpaid hospital charges exceed the amounts listed in the table above, for the corresponding family income levels and their financial means are insufficient to render a payment for services received. Persons qualifying as Medically Indigent will be responsible for 24-monthly payments as noted above, and receive charity care for the balance of unpaid charges.

\* FPG (Federal Poverty Guidelines)

\*\* In addition to meeting the income guidelines, a person's other financial means will be considered in the charity care determination process.

A person without healthcare insurance, who does not qualify for charity care, shall receive an uninsured patient discount, applicable to eligible services as described in Section IV.

Uninsured patients will receive a general discount as noted below. In addition, each System hospital may offer specific pricing to uninsured patients for certain common services by utilizing a predetermined pricing list which is available to uninsured patients for their review prior to receiving services. The specific discounts may be equal to or greater than, but not less than, the general discount amount.

The amount of the general discount is:

Effective Date:	General Discount Amount
November 1, 2010	60.0%



# FINANCIAL ASSISTANCE APPLICATION

This application for Financial Assistance covers services provided by all hospitals within the East Texas Medical Center Regional Healthcare System.

Completed applications can be delivered to the hospital or sent to the address below. If you have any questions regarding financial assistance please contact our Community Benefits Department.

East Texas Medical Center Regional Healthcare System  
 Community Benefits Department  
 P. O. Box 7370  
 Tyler, TX 75711-7370  
 Telephone: (903) 535-6012 or (800) 981-3869  
 FAX: (903) 596-3807  
 Email: [communitybenefits@etmc.org](mailto:communitybenefits@etmc.org)

What ETMC hospital(s) provided services to your family: \_\_\_\_\_

**HOUSEHOLD INFORMATION**

**Patient Name:** \_\_\_\_\_ **Account Number:** \_\_\_\_\_

**Guarantor Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City/State/Zip Code:** \_\_\_\_\_

**Employer Name:** \_\_\_\_\_

**Spouse Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Spouse Employer:** \_\_\_\_\_

**HOUSEHOLD FAMILY MEMBERS:** Provide all family members in household.

	Name	Social Security Number	Date of Birth	Relationship
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

**HOUSEHOLD INCOME FOR ALL FAMILY MEMBERS OVER THE AGE OF 18**

Name	Gross Income	Circle One
_____	_____	Weekly / Monthly / Yearly
_____	_____	Weekly / Monthly / Yearly
_____	_____	Weekly / Monthly / Yearly

**DOCUMENTATION OF HOUSEHOLD INCOME**

Please attach copies of income documentation for each household family member for the most recent three month period. Types of documentation to verify household income include:

- 1. Paycheck Stubs
- 2. Tax Return / IRS W-2
- 3. Social Security Statement
- 4. Workers Compensation Statement
- 5. Unemployment Compensation Statement
- 6. Investment Income
- 7. Proof of Participation in Governmental Assistance Programs including CIDC, Food Stamps, AFDC, Medicaid, etc.
- 8. Bank Statements
- 9. Letter from Employer
- 10. Child Support / Alimony

Other, (Please Describe): \_\_\_\_\_

If self-employed please provide a current profit and loss statement.

**OTHER HOUSEHOLD FINANCIAL RESOURCES**

Checking Account Balance: \_\_\_\_\_ Stocks and Bonds: \_\_\_\_\_

Savings Account Balance: \_\_\_\_\_ Real Estate/Property: \_\_\_\_\_

Other: \_\_\_\_\_ : \_\_\_\_\_ Other: \_\_\_\_\_ : \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Company Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

**OTHER INFORMATION REGARDING FINANCIAL ASSISTANCE**

List any other information you feel would be helpful to us in determining your eligibility for financial assistance.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE READ AND SIGN BELOW**

I affirm that the information made in this application is true and correct to the best of my knowledge and made in good faith. I understand that falsification of information on this application may result in denial of financial assistance. I understand that East Texas Medical Center Regional Healthcare System may verify the financial information stated in this application. I understand that any financial assistance approved may be reversed in the event additional third-party payment is available. I understand that any financial assistance I receive is not a waiver by hospital of its hospital lien for reimbursement of any amount I owe.

\_\_\_\_\_  
Signature of Individual Making Request

\_\_\_\_\_  
Date