

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

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.

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.

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- 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.

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. 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

2009 Federal Poverty Guidelines		Charity Qualification Limits
Size of Family Unit	Maximum Family Income	(200% of FPG*) If Income Does Not Exceed **
1	\$ 10,830	\$ 21,660
2	14,570	29,140
3	18,310	36,620
4	22,050	44,100
5	25,790	51,580
6	29,530	59,060
7	33,270	66,540
8	37,010	74,020
ea. Add'l Person	3,740	7,480

* 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
 Medically Indigent

Exhibit B

2009 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	\$ 10,830	\$ 27,075	\$ 32,490	\$ > 32,490	\$ 2,708	\$ 3,249	10% of
2	14,570	36,425	43,710	> 43,710	3,643	4,371	actual
3	18,310	45,775	54,930	> 54,930	4,578	5,493	annual
4	22,050	55,125	66,150	> 66,150	5,513	6,615	income
5	25,790	64,475	77,370	> 77,370	6,448	7,737	"
6	29,530	73,825	88,590	> 88,590	7,383	8,859	"
7	33,270	83,175	99,810	> 99,810	8,318	9,981	"
8	37,010	92,525	111,030	> 111,030	9,253	11,103	"
ea. Add'l Person	3,740	9,350	11,220	> 11,220	935	1,122	"
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.

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

Exhibit C

A person without healthcare insurance, who does not qualify for charity care, shall receive an uninsured patient discount.

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, 2005	30.0%



East Texas Medical Center
Regional Healthcare System

Exhibit D

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

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