

Title: Financial Assistance and Charity Care Policy

Formulated by: Administration

Approval Required by: Board of Trustees and/or its Audit and Compliance Committee

I. POLICY

Texas Scottish Rite Hospital for Children (“TSRHC” or “Hospital”) provides exceptional care to thousands of children every year. Consistent with its longstanding mission, TSRHC provides care to patients with health care needs within the scope of services provided by the Hospital without regard to a patient’s ability to pay. In furtherance of its mission and values, the Hospital adopts this policy to provide financial assistance in the form of free or discounted care to those patients and/or the party or parties responsible for the patient (“Patient(s)”) who qualify for assistance pursuant to this Financial Assistance and Charity Care Policy (“Policy”).

This Policy sets forth the eligibility criteria, standards, and processes by which the Hospital provides free or discounted care to Patients.

The Hospital provides financial assistance on a consistent and non-discriminatory basis and 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, the Hospital will comply with all applicable federal, state and local laws, rules and regulations.

The TSRHC Board of Trustees Audit and Compliance Committee is responsible for oversight of this Policy. The Hospital Financial Assistance Committee is responsible for (i) establishing, approving and monitoring the procedures and standard forms that operationalize the Policy; and (ii) other responsibilities as set forth in this Policy.

II. ELIGIBILITY CRITERIA

Any Patient is eligible for consideration for financial assistance with the Patient’s obligations for charges for all services provided by the Hospital, including physicians’ professional services and other ancillary services, except as set forth below (collectively “Hospital Charges”). Each Patient’s situation will be evaluated pursuant to the eligibility criteria as set forth in Section V of this Policy, when determining the ability to pay for care and the degree of financial assistance the Patient will receive. The Hospital may adjust the eligibility criteria from time to time based on financial resources available and as necessary to meet the charity care needs of the community.

In certain situations, when a Patient’s circumstances do not satisfy the eligibility criteria requirements under the Policy, a Patient may still be able to obtain financial assistance. In these situations, the Hospital’s Financial Assistance Committee will review all available information and make a determination of the Patient’s eligibility for financial assistance.

III. SERVICES INCLUDED

This Policy applies to the Patient's obligations for all TSRHC Hospital Charges for services provided at TSRHC, except as stated otherwise. Exhibit A lists those providers to whom the Policy does and does not apply, and may be updated from time to time.

The Patient's obligation under certain insurance contracts may be considered for financial assistance under this Policy in accordance with insurance contracts and/or applicable law.

On a case by case basis and after all other sources of assistance have been explored or exhausted, TSRHC will provide prescription medications to a patient whose family has no resources with which to fill physician prescribed medications. These medications will be dispensed in accordance with applicable state and federal statutes and will be done only for inpatients at TSRHC, and/or outpatients in the Hospital-based clinics.

On a case by case basis and after all other sources of assistance have been explored or exhausted, TSRHC will also assist families whose children are in current treatment and require financial assistance with other aspects of a child's care, which might include such things as lodging, transportation, etc.

IV. METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE

A. Application Process

Patients who want to apply for financial assistance shall complete the Financial Assistance/Charity Care Application ("Application") attached as Exhibit B and return it to the Family Services Counselors Office. Application may be made at any time during the continuum of care or after care is received. The Hospital may initiate an Application on behalf of a Patient when the Patient is unable to complete the Application. In addition to applying through the submission of the written Application, the financial assistance application process can be initiated by a Patient requesting assistance in person, over the phone at 214-559-8630, or through the mail at 2222 Welborn Street, Dallas, TX 75219.

Family Services Counselors will attempt to identify families that may qualify for financial assistance prior to a procedure being scheduled and ask the Patient to apply prior to the time of the service being provided, if possible.

Family Services Counselors will refer those Patients who may qualify for participation in a governmental program to the appropriate program, such as Medicaid.

There is no assurance that a Patient who completes and submits an Application will qualify for financial assistance. It is ultimately the Patient's responsibility to provide the necessary information to qualify for assistance under this Policy. In order for the Hospital to process an Application, the Patient must provide the Hospital with all of the information requested on the Application, or if he/she is unable to do so, explain why he/she cannot provide the information.

B. Information Required

1. Income Information

Gross Income means the sum of the total yearly annual gross income or estimated yearly income of the patient, the patient's mother, the patient's father, and/or other party or parties responsible for the patient (each a "Responsible Party").

Gross Income shall be verified in one of the following ways:

- *Third Party Documentation:* IRS Form W-2; Wages and Tax Statement; pay check remittance; tax return; telephone verification with employer; bank statements; Social Security payment remittance; Worker's Compensation payment remittance; Unemployment Insurance payment notice; Unemployment Compensation Determination Letters; or other appropriate indicators of the Patient's income.
- *Written Attestation:* In cases where third-party documentation is unavailable, the Responsible Party may verify the Gross Income through a written attestation.
- *Verbal Attestation:* In cases where third-party documentation is unavailable and the Responsible Party is unable to make a written attestation, the Responsible Party may verify the Gross Income through a verbal attestation. The Hospital employee completing the Application must attest in writing to any such verbal attestation by a Responsible Party.

Note: In those cases where third party documentation is unavailable, the Patient shall provide a reasonable explanation of why the Patient is unable to provide the required third-party verification. Reasonable attempts will be used to verify Patient's attestation and supporting information. The Hospital may provide financial assistance notwithstanding the applicant's failure to provide third-party documentation.

2. Household Size

Household Size means the number of people living in the household of (a) the guarantor, (b) the patient, or (c) the person claiming the patient for tax purposes. This is determined by the primary insurance coverage of the patient as listed below:

- Medicaid or other State Funding – Household where the child lives
- Commercial Insurance or Uninsured – Household of the Responsible Party

C. Determination Process

1. The Family Services Counselors will evaluate a submitted Application in accordance with established financial assistance application processing procedures.
2. The Family Services Counselors will determine the Patient's eligibility for financial assistance and the level of Financial Assistance, if any, for which the Patient qualifies; provided, however, that the Family Services Counselors may, at any time, request that the Hospital's Financial Assistance Committee make such determination.
3. It is the goal of TSRHC to make a determination regarding eligibility as soon as sufficient information regarding resources and eligibility for government assistance is available.

D. Effective Date of Application

Once financial assistance has been approved, it is effective for all outstanding accounts and for all accounts discharged twelve (12) months after the later of the date on which (i) the Hospital receives the completed Application; and (ii) the first billable date of service.

V. FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA/BASIS FOR AMOUNT CHARGED

The level of financial assistance will be based on a classification as Financially Indigent or Medically Indigent, including Catastrophic Medically Indigent, as defined below. A Patient eligible to receive financial assistance under this Policy will not be charged more than the amount generally billed ("AGB") for the services rendered. In determining the AGB, TSRHC is using the look back method in which the AGB percentages are based on Medicaid rates, as outlined in Internal Revenue Code Section 501(r). TSRHC may change the methodology for calculating the AGB in the future, in accordance with the applicable regulations. Information regarding the calculation of the AGB and the AGB percentage used to calculate the AGB may be obtained in writing and free of charge at Family Services Counselors / Admissions, 2222 Welborn Street, Dallas TX 75219.

A. Financially Indigent

1. Financially Indigent means a Patient whose Gross Income is less than or equal to 200% of the Federal Poverty Guidelines ("FPG").
2. A Patient will be deemed to qualify as Financially Indigent, and shall not be required to submit an Application, upon providing proof of participation in any of the following programs:
 - Medicaid
 - Children's Health Insurance Program (CHIP)
 - County Indigent Health Program
 - AFDC
 - Food Stamps
 - WIC
 - Tex Care Partnership

- Proof that the Patient has been deemed financially indigent at another healthcare facility
 - Other similar means tested programs
3. Financially Indigent Patients are eligible for a 100% discount on all Hospital Charges remaining after payment by third party payors.

Example: A patient with a Household Size of 3 (as defined below in Section 6.B.) and Gross Income of \$39,000 is eligible for a financial assistance discount of 100%.

B. Medically Indigent

1. Medically Indigent means a Patient (i) whose combined medical or hospital bills from the previous 12 months, after payment by all third parties, exceed 1% of the Patient's Gross Income; (ii) whose Gross Income is greater than 200% but less than or equal to 1000% of the FPG; and (iii) who is unable to pay the outstanding patient account balance. The medical or hospital bills described in part (i) hereof may relate to the Hospital and other affiliated and unaffiliated providers and may include, without limitation, the annualized and unreimbursed costs incurred by the Patient in connection with the purchase of medications and/or medical supplies ("Unreimbursed Medical Expenses").
2. Patients deemed Medically Indigent will qualify for a discount on all Hospital Charges remaining after payment by third party payors. The discount shall be equal to the greater of (i) the applicable discount set forth on the Fee Adjustment Scale attached hereto as Exhibit C; (ii) the amount necessary to ensure that the Patient's payment obligation to the Hospital after application of the discount is equal to 1% of the Patient's Gross Income, and (iii) the amount necessary to ensure that the Patient's payment obligation is not greater than the AGB.

Example: A Patient has a Gross Income of \$50,000, a Household Size of 3, and combined medical bills from the previous 12 months, after payment by third party payors, of \$15,000, and he is unable to pay his outstanding account balance of \$12,000. The applicable discount set forth on the Fee Adjustment Scale attached hereto as Exhibit C would be 80%, meaning that the Patient would need to pay \$2,400. However, since \$2,400 is still greater than 1% of the Patient's Gross Income, he would get a further discount such that he would only need to pay \$500 (or 1% of his Gross Income).

C. Catastrophic Medically Indigent

1. Catastrophic Medically Indigent means a Patient (i) whose combined medical or hospital bills from the previous 12 months, after payment by all third parties, exceed 1% of the Gross Income; (ii) whose Gross Income is greater than 1000% of the FPG; and (iii) who is unable to pay the outstanding patient account balance. The medical or hospital bills

described in part (i) hereof may relate to services provided by the Hospital and other affiliated and unaffiliated providers and may include, without limitation, Unreimbursed Medical Expenses.

2. Patients deemed Catastrophic Medically Indigent will qualify for a discount on all Hospital Charges remaining after payment by third party payors. The discount shall be the greater of (i) the amount necessary to ensure that the Patient's payment obligation to Hospital after application of the discount is equal to 1% of the Patient's Gross Income; or (ii) the amount necessary to ensure that the Patient's payment obligation is not greater than the AGB.

Example: A Patient has a Gross Income of \$250,000, a Household Size of 3, and combined medical bills from the previous 12 months, after payment by third party payors, of \$50,000, and he is unable to pay his outstanding account balance of \$12,000. Since \$50,000 is greater than 1% of the Patient's Gross Income, the Patient would get a discount such that he would only need to pay \$2,500 (or 1% of his Gross Income).

VI. FINANCIAL ASSISTANCE COMMITTEE

- A. The Hospital's Financial Assistance Committee shall be comprised of a representative from the Finance Department, a representative from the Revenue Cycle Department, a representative from the Family Services Department, a representative from the Patient Access Department, the General Counsel and/or designee, and others deemed necessary by the Committee. The Chair of the Committee shall be appointed by the Chief Financial Officer.
- B. The Financial Assistance Committee shall be responsible for ensuring that this Policy is appropriately and uniformly applied and utilized by the Hospital. Additionally, the Financial Assistance Committee shall implement non-material changes to the Policy as needed in order to accomplish the intent of the Policy.
- C. In certain situations, it may be appropriate to grant a Patient financial assistance even though the Patient's financial situation does not satisfy the requirements set forth in the Hospital's Financial Assistance Eligibility Criteria Guidelines. In these situations, the Hospital's Financial Assistance Committee may review the Application and other pertinent information and make a determination as to the Patient's eligibility for assistance.

VII. ACCOUNT BALANCE

This Policy does not alter or modify amounts owed by third-party payors nor alter or modify policies concerning efforts to obtain payments from third-party payors.

A Patient's account will be reviewed for financial assistance eligibility and the appropriate application of any applicable third-party payment, and/or discounts before initiating a statement to the Patient. Once a Patient qualifies for financial assistance, the Patient shall be notified of the amount qualifying under the Policy, and no further billing actions shall be taken for amounts qualifying under the Policy. After a Patient's account balance is reduced by any discounts available under this Policy, the Patient will be responsible for

the remainder of his or her outstanding account balance. TSRHC will send three post-discharge billing statements over a 120 day period. Each post-discharge billing statement will notify the Patient that financial assistance is available for eligible individuals, including a phone number for inquiries about financial assistance and a website where additional information can be obtained. A free copy of TSRHC billing policies may be obtained by calling 214-559-8630.

Information regarding this Policy and how to apply for financial assistance will also be provided during phone conversations with Patients regarding financial charges and/or account balances. If payment in full is not possible and the Patient does not qualify for financial assistance, then a payment plan may be offered.

VIII. REASONS FOR DENIAL

A. Services Not Included

The Hospital reserves the right to exclude certain services from coverage under this Policy.

B. Information Falsification

Financial assistance will be denied to a Patient if the Patient provides false information on the Application, such as false information relating to the Patient's financial means to pay for care. This includes, but is not limited to, false information regarding the Patient's Gross Income, other resources available, number in household, medical expenses, or household expenses.

C. Third Party Settlement

Patients who receive a third-party financial settlement associated with care received at or rendered by the Hospital are expected to use any such settlement amount to satisfy any and all Hospital Charges. Such Patient shall be responsible for all Hospital Charges, regardless of whether the Patient has previously been granted charity care or financial assistance under this Policy.

IX. PUBLICATION OF FINANCIAL ASSISTANCE POLICY

In an effort to ensure that those families who may be eligible for financial assistance are familiar with the Policy, TSRHC will widely publicize information regarding the Policy. Each person who seeks health care service at the Hospital shall be offered information in the appropriate language, if possible, about the Hospital's Financial Assistance/Charity Care program, including the eligibility criteria and the application process. Family Services Counselors will be available to communicate with and assist patients regarding the Policy and the completion of the Application.

X. EMERGENCY MEDICAL CARE POLICY

TSRHC does not have an emergency department. The Hospital shall provide, however, without discrimination, appraisal and initial care for emergency medical conditions to individuals regardless of whether they are eligible for financial assistance under this Policy in accordance with its obligations under the Emergency Medical Treatment and Labor Act, other applicable law, and the Hospital's Emergency Services Policy.

Further, the Hospital shall not engage in actions that discourage individuals from seeking emergency medical care, such as by demanding that patients seeking emergency services pay before receiving initial treatment for emergency medical conditions or by permitting debt collection activities that interfere with the appraisal and provision, without discrimination, of such initial treatment.

Approved to become effective _____ by:

Robert L. Walker
President/CEO

William R. Huston
Senior Vice President and
Chief Financial Officer

Matt Chance
Senior Vice President, Operations

PROVIDERS TO WHOM POLICY DOES AND DOES NOT APPLY



Patient ID Number: _____

Financial Assistance/Charity Care Application

Patient Name: _____ DOB: _____ Sex: Male / Female

Telephone Number: _____ SSN: _____

Address: _____ County: _____
Street / City / State / Zip Code

Caregiver/ Guardian Information	Caregiver / Guardian Information
Name: _____ DOB: _____	Name: _____ DOB: _____
Relationship to Patient: _____	Relationship to Patient: _____
Address: _____ <small>Street / City / State / Zip Code</small>	Address: _____ <small>Street / City / State / Zip Code</small>
SSN: _____	SSN: _____
Phone: _____	Phone: _____
Employer: _____ <small>Name / Street / City / State / Zip Code</small>	Employer: _____ <small>Name / Street / City / State / Zip Code</small>

Patient's Siblings in the Same Household				
Name	DOB	Age	Sex	Also a TSRHC Patient (seen in last 12 Months)
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Marital Status of Caregivers: Married Divorced Separated Single Widowed

What insurance(s) (if any) does the patient currently have?

None Medicaid CHIP Commercial Insurance: _____ Other : _____

Policy Number: _____ Group Number: _____

Who is listed as the subscriber on the patient's insurance? _____

Eligibility Information
<p>Please provide the income for each of the following persons in your household (if applicable).</p> <p style="text-align: center;">Circle one</p> <p>Patient \$ _____ Hr/ Wk /2xMonth /Bi-weekly /Year Patient's Caregiver/Guarantor \$ _____ Hr /Wk/2xMonth /Bi-weekly /Year</p> <p>Patient's Caregiver / Guarantor \$ _____ Hr /Wk /2xMonth /Bi-weekly /Year Other \$ _____ Hr /Wk /2xMonth /Bi-weekly /Year</p> <p>Family Gross Income*: \$ _____</p> <p><small>* Gross Income is the sum of the gross income of the patient, patient's mother, patient's father and/or other responsible party.</small></p> <p>Unreimbursed Medical Expenses*: \$ _____</p> <p><small>*These are the annualized and unreimbursed costs incurred by the family and include bills for services provided by the Hospital and other unreimbursed medical expenses.</small></p> <p>Number of Family Members living in household*: _____</p> <p><small>*This number is to include the patient, patient's mother, patient's father, dependents of the patient's mother and dependents of the patient's father.</small></p> <p>Income Verification: Provide documentation that reflects total household wages or proof of participation in a government assistance program.</p>

*This number is to include the patient, patient's mother, patient's father, dependents of the patient's mother and dependents of the patient's father.

Income Verification: Provide documentation that reflects total household wages or proof of participation in a government assistance program.

Financial Assistance / Charity Care Application

Please initial below:

_____ I/we declare that the answers I/we have given on this application are true and correct to the best of my/our knowledge.

_____ I/we agree to tell the Hospital as soon as possible, if there are any changes in the information provided in this application.

_____ I/we understand that the Hospital is 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 Hospital 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 Scottish Rite Hospital of Children (TSRHC) and that I/we may appeal decision in writing with additional documentation.

If unable to provide proof of income, please explain why:

I/we ask Texas Scottish Rite Hospital for Children to determine if I/we are eligible for help in paying for my/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 TSRHC or its agents may check these facts for accuracy and by my signature hereby authorize my employer or any individual listed on this Application to certify or provide additional details with respect to the information provided in this Application. I am (we are) aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance. 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/our child's hospital bill.

Signature of Mother/Guarantor: _____

Date: _____

Signature of Father/Guarantor: _____

Date: _____

FOR OFFICE USE ONLY

Family qualifies for a discount of _____% on all Hospital Charges; provided, however, that the amount due after such discount will in all cases be limited to 1% of the family's gross income. The amount due, after application of the discount, is: \$_____).

Some portions of this application were completed by a TSRHC staff member. Those areas have been identified by the staff member's initials.

Printed Name: _____

Signature: _____ **Date:** _____

**%
DISCOUNT**

.....1,000% FPG*.....

.....800% FPG*.....

.....600% FPG*.....

.....400% FPG*.....

.....200% FPG*.....

.....100% FPG*.....

0 %

Charges to family from TSRHC limited to 1% of gross annual income if family's medical expenses from all providers is in excess of 1% of the household's gross annual income.

10 %

20 %

30 %

40 %

50 %

60 %

70 %

80 %

90 %

**Patient/Family responsibility
discounted 10% - 90%**

Charges to family from TSRHC limited to 1% of gross annual income if family's medical expenses from all providers is in excess of 1% of the household's gross annual income.

100 %

No charge to patient family

* FEDERAL POVERTY GUIDELINE
 see back for more information.

APPLICATION PROCESS

- Complete application
- Provide proof of household income and proof of medical expenses for the family from the past 12 months
- Proof of enrollment in Government Assistance Program (Medicaid, CHIP, Food Stamps, WIC, etc.) if applicable

CONTACT INFO

FOR FAMILY SERVICES COUNSELORS

 **214-559-8630**



CRAYON CARE QUALIFICATION AND DISCOUNT SCALES

2017 Federal Poverty Guidelines as established by the
Department of Health & Human Services

\$20,420: Federal Poverty Limit for a household of three dependents

Household Size		3 or less
Income Range		Discount
\$0	\$40,840	100%
\$40,841	\$61,260	90%
\$61,261	\$81,680	80%
\$81,681	\$102,100	70%
\$102,101	\$122,520	60%
\$122,521	\$142,940	50%
\$142,941	\$163,360	40%
\$163,361	\$183,780	30%
\$183,781	\$193,990	20%
\$193,991	\$204,200	10%
\$204,201	and up	0%

Household Size		4
Income Range		Discount
\$0	\$49,200	100%
\$49,201	\$73,800	90%
\$73,801	\$98,400	80%
\$98,401	\$123,000	70%
\$123,001	\$147,600	60%
\$147,601	\$172,200	50%
\$172,201	\$196,800	40%
\$196,801	\$221,400	30%
\$221,401	\$233,700	20%
\$233,701	\$246,000	10%
\$246,001	and up	0%

Household Size		5
Income Range		Discount
\$0	\$57,560	100%
\$57,561	\$86,340	90%
\$86,341	\$115,120	80%
\$115,121	\$143,900	70%
\$143,901	\$172,680	60%
\$172,681	\$201,460	50%
\$201,461	\$230,240	40%
\$230,241	\$259,020	30%
\$259,021	\$273,410	20%
\$273,411	\$287,800	10%
\$287,801	and up	0%

Household Size		6
Income Range		Discount
\$0	\$65,920	100%
\$65,921	\$98,880	90%
\$98,881	\$131,840	80%
\$131,841	\$164,800	70%
\$164,801	\$197,760	60%
\$197,761	\$230,720	50%
\$230,721	\$263,680	40%
\$263,681	\$296,640	30%
\$296,641	\$313,120	20%
\$313,121	\$329,600	10%
\$329,601	and up	0%

Household Size		7
Income Range		Discount
\$0	\$74,280	100%
\$74,281	\$111,420	90%
\$111,421	\$148,560	80%
\$148,561	\$185,700	70%
\$185,701	\$222,840	60%
\$222,841	\$259,980	50%
\$259,981	\$297,120	40%
\$297,121	\$334,260	30%
\$334,261	\$352,830	20%
\$352,831	\$371,400	10%
\$371,401	and up	0%

Household Size		8
Income Range		Discount
\$0	\$82,640	100%
\$82,641	\$123,960	90%
\$123,961	\$165,280	80%
\$165,281	\$206,600	70%
\$206,601	\$247,920	60%
\$247,921	\$289,240	50%
\$289,241	\$330,560	40%
\$330,561	\$371,880	30%
\$371,881	\$392,540	20%
\$392,541	\$413,200	10%
\$413,201	and up	0%

Household Size		9
Income Range		Discount
\$0	\$91,000	100%
\$91,001	\$136,500	90%
\$136,501	\$182,000	80%
\$182,001	\$227,500	70%
\$227,501	\$273,000	60%
\$273,001	\$318,500	50%
\$318,501	\$364,000	40%
\$364,001	\$409,500	30%
\$409,501	\$432,250	20%
\$432,251	\$455,000	10%
\$455,001	and up	0%

Household Size		10
Income Range		Discount
\$0	\$99,360	100%
\$99,361	\$149,040	90%
\$149,041	\$198,720	80%
\$198,721	\$248,400	70%
\$248,401	\$298,080	60%
\$298,081	\$347,760	50%
\$347,761	\$397,440	40%
\$397,441	\$447,120	30%
\$447,121	\$471,960	20%
\$471,961	\$496,800	10%
\$496,801	and up	0%

