Healthcare Systems of America	**Charity Care/Financial Assistance** **Chapter: Finance** **Policy Number: FIN 27** **Origination Date: 1/27/2025** **Last Revised: 2/24/2025**

Policy

Healthcare Systems of America (HSA) is committed to meeting the health care needs of members of the HSA communities who are unable to pay for medically necessary care received at HSA healthcare facilities in the State of Texas, including without limitation those who are uninsured, underinsured, ineligible for a government program, or otherwise unable to make payment.

This policy establishes a framework pursuant to which Medical Center of Southeast Texas will properly identify patients that may qualify for financial assistance with their medical expenses under the guidelines and requirements set forth below.

HSA provides a reasonable amount of its emergency and medically necessary services at a discounted rate or without charge to eligible patients who cannot afford to pay for care, to limit expected payment from eligible patients that are uninsured or who have high medical costs with income at or below 400% of the federal poverty level.

Medically necessary services (consistent with generally accepted standards of medicine in the community) of this facility will be available as uncompensated services to eligible patients.

Eligibility for financial assistance is determined by the inability of a patient to pay, versus bad debt as the unwillingness of the patient to pay. Charity Care does not include bad debt, contractual adjustments, or unreimbursed costs. The financial status of each patient should be determined so that an appropriate classification and distinction can be made between charity care and bad debt.

All individuals presenting on hospital property requesting emergency medical services, individuals presenting to a Dedicated Emergency Department requesting medical services, and patients arriving/presenting via ambulance requesting medical services shall receive an appropriate Medical Screening Examination and Stabilization services as required by the Emergency Medical Treatment and Active Labor Act (“EMTALA”), 42 U.S.C. Section 1395 and all Federal regulations and interpretative guidelines promulgated thereunder.

Scope

This policy applies to HSA Texas facilities.

Definitions

Federal Poverty Guidelines (FPG): A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits such as health insurance and/or financial assistance.

Family: Includes the patient, the patient’s spouse or domestic partner, parent, and/or caretaker of minors and dependent under the age of 21 whether living at home or not.

Proof of Income: Total salaries, wages, and cash receipts before taxes. If the patient/applicant reports zero income, the patient/applicant will be required to report on the application how the patient/applicant and his/her family are surviving.

Procedure

A. Eligibility Requirements

1. Uninsured patients who do not have the ability to pay as determined by the financial guidelines in this policy.
2. Patients who have Medicaid Emergency coverage (and no share of cost) and whose services are not covered for a particular episode or partial episode of care. (the patient is presumed to meet the charity care eligibility requirements);
3. Uninsured patients that were screened, stabilized, or admitted through the Emergency Department that cannot be reached will be classified as charity care.
4. There are instances when a patient may appear eligible for charity care discounts, but there is a lack of supporting documentation. Presumptive eligibility charity maybe determined on the basis of individual life circumstances that may include but are not limited to:
    a. State-funded prescription programs;
    b. Homeless or received care from a homeless clinic or shelter;
    c. Participation in Women, Infants and Children Programs (WIC);
    d. Food stamp eligibility;
    e. Subsidized school lunch program eligibility;
    f. Low income/subsidized housing is provided as a valid address;
    g. Patient is deceased with no known estate; and
    h. Patients who are currently eligible for Medicaid but were not eligible in one to three months prior to eligibility are presumed to be eligible for charity.
    i. Undocumented patients
5. Insured patients whose coverage is inadequate to cover a catastrophic situation;
6. Persons whose income is sufficient to pay for basic living costs but not medical care, and also those persons with generally adequate incomes who are suddenly faced with catastrophically large medical bills;
7. Insured and uninsured patients who demonstrate ability to pay part but not all of their liability. For example, those who have an out of pocket that exceeds 10% of their annual net family income in the prior twelve months.

B. Eligibility Procedures

1. In addition to the eligibility requirements above, consider the following factors to determine the amount of assistance for which a patient is eligible at the time of service:

   a. Consider the patient's individual or family income, as appropriate, using the income guidelines in this policy.

   b. Consider individual or family net worth including all liquid and non-liquid assets owned, less liabilities and claims against assets. Monetary assets shall not include retirement or deferred-compensation plans. Furthermore, the first ten thousand ($10,000) dollars of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50% of a patient's monetary assets over the first ten thousand ($10,000) dollars be counted in determining eligibility.

   c. Consider employment status along with future earnings sufficient to meet the obligation within a reasonable period of time. Consider family size, family includes the patient, the spouse or domestic partner, parent and/or caretaker of minors and dependent children less than 21 years of age, whether living at home or not.

   d. Consider other financial obligations including living expenses and other items of a reasonable and necessary nature.

   e. Consider the amount(s) and frequency of hospital and other healthcare/medication bill(s) in relation to all of the factors outlined above.

   f. All other resources must be applied first, including third-party payers. If a patient does not have Medicaid but would qualify, he/she should be encouraged to cooperate with the application process.

2. Determine the appropriate amount of financial assistance in relation to the amounts due after applying all other eligible resources. A patient who can afford to pay for a portion of the services will be expected to do so. Reasonable payment guidelines as defined in this policy and by law will be incorporated. Part of an account might be paid by a third party, part by the patient; part may be adjusted to a charity write-off.

3. Request evidence of eligibility especially for large balance accounts. The patient must provide supporting documentation of income which can include:
   a. Recent pay stubs such as paychecks, General Relief, Social Security, pension, unemployment or disability check stubs, or tax returns;

   b. Application verification may include accessing of the patient/guarantor's credit report. The patient must sign the charity form or Consent of Admissions prior to accessing his/her credit information.

4. Determine eligibility for financial assistance at the time of admission/pre-registration, or as soon as possible thereafter. In some cases, it can take investigation to determine eligibility, particularly when a patient has limited ability to provide needed information. Also, because of complications unforeseen at the time of admission, the patient may need to be reclassified as a full or partial charity.
5. Financial counselors, registration clerks, care managers, Patient Accounting staff and patients can initiate process.

C. Application

See policy attachment "Financial Assistance Application".

D. Documentation Requirements

1. All patients must complete the "Financial Assistance Application" to be considered for Financial Assistance unless they are eligible for Presumptive Financial Assistance. An unsigned application can be deemed acceptable if the patient is physically unable to sign or does not live within the vicinity of the hospital or unable to return the application by mail. In these situation's only, the hospital representative should complete all questions on the application, sign it and document why the patient is unable to sign the application.

Attachments

Amount of Financial Assistance/Charity Care Determination

Financial Assistance Application

References

Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. Section 1395

2024 Federal Poverty Guidelines, Federal Register Notice January 17, 2024:
https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

SJMC Policy: RI 01 Emergency Medical Treatment and Labor Act (EMTALA)

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Review and Approval

The following Healthcare Systems of America personnel have reviewed and approved this policy:

Action Date	Contact	Approved by	Description
01/27/2025	**Sr. Vice President, Corporate Revenue Cycle, American Healthcare Systems (known as Healthcare Systems of America [HSA)]** **Director, Patient Access** **Director, Business Office**	Healthcare Systems of America/Medical Center of Southeast Texas **Policy Oversight Management Committee (POMC)** [2/06/2025] Healthcare Systems of America/Medical Center of Southeast Texas **Senior Leadership** [2/06/2025] Healthcare Systems of America/Medical Center of Southeast Texas **Medical Executive Committee** [2/11/2025] Healthcare Systems of America/Medical Center of Southeast Texas **Governing Board** [2/24/2025]	**New HSA policy released by Corporate to Texas and Louisiana facilities. Formatted to SJMC policy template.**

Note: this policy requires annual review and updated for revised Federal Poverty Guidelines.

Amount of Financial Assistance/Charity Care Determination is Based on

Methodology: HSA uses the "Sliding Scale Method" to determine the dollar amount to be considered as charity care for eligible patients.

Charity Care: Patient applications that show that family income at or below 200% of the current year Federal Poverty Guidelines (FPL) will be approved for no-cost to the patient.

Discounted Charity Care: Patient applications that show that family income between 201% and 400% FPL will be granted a charity care discount, the lessor of the Amounts General Billed (AGB) or discounts as outlined below.

HSA will utilize the Prospective Medicare methodology to determine the AGB for inpatient and outpatient accounts when determining patient liability for individuals who qualify for financial assistance. The billed amount will not exceed the AGB.

The FPL for the current year can be obtained from the following website:

https://aspe.hhs.gov/poverty-guidelines

Federal Poverty Level	100%	200% <=	201-250%	251 -300%	301-325%	326-400%
Persons	Gross Annual Income	Gross Monthly Income	Gross Monthly Income	Gross Monthly Income	Gross Monthly Income	Gross Monthly Income
1	$ 15,060.00	$ 2,510.00	$ 3,137.50	$ 3,765.00	$ 4,078.75	$ 5,020.00
2	$ 20,440.00	$ 3,406.67	$ 4,258.33	$ 5,110.00	$ 5,535.83	$ 6,813.33
3	$ 25,820.00	$ 4,303.33	$ 5,379.17	$ 6,455.00	$ 6,992.92	$ 8,606.67
4	$ 31,200.00	$ 5,200.00	$ 6,500.00	$ 7,800.00	$ 8,450.00	$ 10,400.00
5	$ 36,580.00	$ 6,096.67	$ 7,620.83	$ 9,145.00	$ 9,907.08	$ 12,193.33
6	$ 41,960.00	$ 6,993.33	$ 8,741.67	$ 10,490.00	$ 11,364.17	$ 13,986.67
7	$ 47,340.00	$ 7,890.00	$ 9,862.50	$ 11,835.00	$ 12,821.25	$ 15,780.00
8	$ 52,720.00	$ 8,786.67	$ 10,983.33	$ 13,180.00	$ 14,278.33	$ 17,573.33
Add $5,380 for each additonal person						
Uninsured Patient Amount to Pay	0%	0%	30% AGB	45% ABG	60% of AGB	80% of AGB
Under-insured Patient Amount to Pay	0%	20% of Balance	40% of Balance	60% of Balance	80% of Balance	80% of Balance

NOTE: The AGB is the maximum amount that can be collected from patients that qualify for charity care or as otherwise allowed under this policy, regardless of the percentages shown above.

Financial Assistance Application

Healthcare Systems of America Financial Assistance Program provides financial assistance to patients with medically necessary healthcare needs with low-income, uninsured or underinsured, ineligible for a government program, and is otherwise unable to pay for medically necessary care based on their individual family financial situation. To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Name _____ Account Number_____

Address_____ Phone number_____

_____ Social Security _____

Date of Birth ___ /___ /___ Sex____ M=Male F=Female Do you own a home? Yes (__) No (__)

Number of dependents filed on tax return: _____ Do you own other property? Yes (__) No (__)

List Dependents: Do you own automobiles? Yes (__) No (__)

Name	Relationship	Age	Gender

Household Banking Information **Name**_____ **Balance**_____

Business Banking Information **Name**_____ **Balance**_____

Wages/Income	**Monthly**	**Annual**
Self Wages		
Spouse Wages		
Other Family Member Wages		
Social Security		
Unemployment Benefits		
Retirement / Pensions		
Alimony / Child Support		
Military Family Allotments		
Pensions		
Income from Rent, Dividends, Interest		
Expenses	**Monthly**	**Annual**
Mortgage / Rent		
Utilities		
Auto Loans		
Hospital Bills		
Telephone		
Food		
Credit Cards		
Gasoline		
Child Care		
Other		

Please send the most recent following supporting documentation: Income Tax Filings or W-2s, 3 Bank Statements, 2 Pay Check Stubs, and proof of expenses.

My signature attests that the information I have provided on this form is accurate and true to the best of my knowledge.

_____ _____ _____

Print Name **Signature** **Date**

Financial Assistance Determination Worksheet (Office Use Only)	
Patient Name:	
Accounts Number(s):	
Total Yearly Income:	Total Combined Charges:
Number in Household:	

Select the type of documentation or income verification provided for review from list below:
☐ IRS Form W-2, Wage and Earnings Statement
☐ Paycheck Remittance
☐ Tax Return
☐ Social Security, Work Comp or Unemployment Comp Letter
☐ Government Program
☐ Written verification by employer
☐ Bank Statements
☐ Written Attestation (Patient signed "Financial Assistance Application" verifying total yearly income)
☐ Verbal Attestation (Patient verbally verified total yearly income)
☐ Patient Deceased
☐ Other, Please specify:

Is total yearly income within the Federal Poverty Guidelines (FPG)? *Reference "Schedule A"*
Select appropriate answer/determination in response to the question above:
☐ **YES**, Approved for 100% financial assistance as **Financially Indigent**
☐ **YES**, Approved for 100% financial assistance as **Presumptive**
☐ **YES**, Approved for 100% financial assistance as **Undocumented**
☐ **YES**, Approved for 100% financial assistance as **Special Circumstance**
☐ **NO, Does not qualify for assistance**

Approval/ Authorization of Financial Assistance Write-off:	
Review of the "Financial Assistance Application" and the provided supporting documentation has been completed on my behalf. I can attest that the financial assistance determination was based on the provided information and meets FIN 27 Charity Care Financial Assistance policy requirements.	
BOM:	Date:
CEO:	Date:
CFO:	Date:

DATE:

Patient Name:
Address:

Account: Patient Account

Financial Assistance Decision Determination

Dear **Mr/Mrs Patient**

We would like to thank you for choosing **Hospital name** as your healthcare provider. We have reviewed your financial assistance application submitted and are pleased to inform you that you have been approved for **100%** financial assistance**,** for the below mentioned accounts:

Account #	Date of Service	Amount Approved

Should you have any questions or concerns regarding your financial application, please do not hesitate to contact me.

Sincerely,
Your Name
Phone: **Your Phone Number**

DATE:

Patient Name:
Address:

Account: Patient Account

Financial Assistance Decision Determination

Dear **Mr/Mrs Patient**

We would like to thank you for choosing **Hospital name** as your healthcare provider. We have reviewed your financial assistance application submitted and unfortunately at this time, assistance has been denied. The reason for denial is: **Insert specific brief explanation**.

You have the right to appeal this decision. Should you choose to appeal this decision, you must complete the attached Appeal/Dispute Form and address the written appeal within 30 calendar days from the date of this determination letter to:

Insert Name of Designated Person

If you have any questions or concerns regarding this notification or your financial application, please do not hesitate to contact me.

Sincerely,
Your Name
Phone: **Your Phone Number**