

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.

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.

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.

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 Patient's eligibility under the Policy, and any amount owed by the Patient after the application of the discount shall be included in the Patient's post-discharge billing statement(s). 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.

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.

Each post-discharge billing statement sent 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.

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 October 1, 2012 by:



Robert L. Walker
President/CEO



William R. Huston
Senior Vice President and
Chief Financial Officer



Matt Chance
Senior Vice President, Operations

Date originated: 1/26/2012
Date revised: 9/8/14, 5/19/16, 9/15/16
Date reviewed:

PROVIDERS TO WHOM POLICY DOES AND DOES NOT APPLY

This Financial Assistance and Charity Care Policy applies to all providers delivering emergency or medically necessary care at TSRHC unless otherwise noted.



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>

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 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 (TSRHC) 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 Caregiver/Guardian: _____

Date: _____

Signature of Caregiver/Guardian: _____

Date: _____

Remember to submit: Income verification & if applicable, proof of 1% of your annual gross income in medical expenses for the family from the past 12 months.

FOR OFFICE USE ONLY	
<input type="checkbox"/>	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: \$_____.
<input type="checkbox"/>	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: _____	Date: _____
Signature: _____	Date: _____

Crayon Care Qualification and Discount Scales

2019 Federal Poverty Guidelines as established by the Department of Health & Human Services
 \$21,330 Federal Poverty Limit for a household of three dependents

Household Size		3 or less
Income Range		Discount
\$0	\$42,660	100%
\$42,661	\$63,990	90%
\$63,991	\$85,320	80%
\$85,321	\$106,650	70%
\$106,651	\$127,980	60%
\$127,981	\$149,310	50%
\$149,311	\$170,640	40%
\$170,641	\$191,970	30%
\$191,971	\$202,635	20%
\$202,636	\$213,300	10%
\$213,301	and up	0%

Household Size		4
Income Range		Discount
\$0	\$51,500	100%
\$51,501	\$77,250	90%
\$77,251	\$103,000	80%
\$103,001	\$128,750	70%
\$128,751	\$154,500	60%
\$154,501	\$180,250	50%
\$180,251	\$206,000	40%
\$206,001	\$231,750	30%
\$231,751	\$244,625	20%
\$244,626	\$257,500	10%
\$257,501	and up	0%

Household Size		5
Income Range		Discount
\$0	\$60,340	100%
\$60,341	\$90,510	90%
\$90,511	\$120,680	80%
\$120,681	\$150,850	70%
\$150,851	\$181,020	60%
\$181,021	\$211,190	50%
\$211,191	\$241,360	40%
\$241,361	\$271,530	30%
\$271,531	\$286,615	20%
\$286,616	\$301,700	10%
\$301,701	and up	0%

Household Size		6
Income Range		Discount
\$0	\$69,180	100%
\$69,181	\$103,770	90%
\$103,771	\$138,360	80%
\$138,361	\$172,950	70%
\$172,951	\$207,540	60%
\$207,541	\$242,130	50%
\$242,131	\$276,720	40%
\$276,721	\$311,310	30%
\$311,311	\$328,605	20%
\$328,606	\$345,900	10%
\$345,901	and up	0%

Household Size		7
Income Range		Discount
\$0	\$78,020	100%
\$78,021	\$117,030	90%
\$117,031	\$156,040	80%
\$156,041	\$195,050	70%
\$195,051	\$234,060	60%
\$234,061	\$273,070	50%
\$273,071	\$312,080	40%
\$312,081	\$351,090	30%
\$351,091	\$370,595	20%
\$370,596	\$390,100	10%
\$390,101	and up	0%

Household Size		8
Income Range		Discount
\$0	\$86,860	100%
\$86,861	\$130,290	90%
\$130,291	\$173,720	80%
\$173,721	\$217,150	70%
\$217,151	\$260,580	60%
\$260,581	\$304,010	50%
\$304,011	\$347,440	40%
\$347,441	\$390,870	30%
\$390,871	\$412,585	20%
\$412,586	\$434,300	10%
\$434,301	and up	0%

Household Size		9
Income Range		Discount
\$0	\$95,700	100%
\$95,701	\$143,550	90%
\$143,551	\$191,400	80%
\$191,401	\$239,250	70%
\$239,251	\$287,100	60%
\$287,101	\$334,950	50%
\$334,951	\$382,800	40%
\$382,801	\$430,650	30%
\$430,651	\$454,575	20%
\$454,576	\$478,500	10%
\$478,501	and up	0%

Household Size		10
Income Range		Discount
\$0	\$104,540	100%
\$104,541	\$156,810	90%
\$156,811	\$209,080	80%
\$209,081	\$261,350	70%
\$261,351	\$313,620	60%
\$313,621	\$365,890	50%
\$365,891	\$418,160	40%
\$418,161	\$470,430	30%
\$470,431	\$496,565	20%
\$496,566	\$522,700	10%
\$522,701	and up	0%