**SUBJECT:** **CHARITY CARE POLICY**
Policy: BO 160

Effective Date: 5/19/15
Revised Date:
Review Dates: 5/31/16; 6/26/17; 6/11/18; 6/17/19; 12/16/19, 8/4/21

## POLICY (verify per hospital and partnership agreement)

In accordance with the Partnership Agreement, "Agreement" between Texas Health Arlington Memorial Hospital and Kindred Healthcare, Texas Rehabilitation Hospital of Arlington is required to adopt the Charity Care Policy of Texas Health Arlington Memorial. To that end, Texas Rehabilitation Hospital of Arlington has adopted this policy.

As a part of Texas Rehabilitation Hospital of Arlington obligation to provide charity care consistent with the partner Hospital charity care policy and as part of Texas Rehabilitation Hospital of Arlington stewardship duty to use its resources as effectively as possible, manage its business affairs prudently and well, and preserve its capacity to continue serving in future years while fulfilling current needs, Texas Rehabilitation Hospital of Arlington strives to identify the dollar volume of charity care it provides to patients who cannot pay for hospital care because they lack the necessary financial resources. Identification of Charity Care will assist Texas Rehabilitation Hospital of Arlington in providing care to a segment of the community served by Texas Rehabilitation Hospital of Arlington who cannot pay for that care and allow Texas Rehabilitation Hospital of Arlington to better concentrate its collection efforts on the accounts that are collectible.

## GUIDELINES

Charity Care includes care to individuals who lack the ability to pay as determined by Texas Rehabilitation Hospital of Arlington, utilizing the partner Hospital's guidelines as outlined below. Uncollected accounts for other patients shall be subjected to full collection efforts, and if not collected, shall be considered for bad debt. All or part of Texas Rehabilitation Hospital of Arlington bill may be considered charity care.

The determination of the ability to pay may take into account a number of variables including, but not limited to:

- Earning status and potential of the patient and family
- Other sources of income and assets
- Level and type of liabilities
- Ability to obtain additional credit
- Amount and frequency of hospital/medical bills
- Family size

Patients eligible for charity consideration, including both Financially Indigent and Medically Indigent applicants who have inadequate resources to pay for services provided.

Financially Indigent patients include those patients who are uninsured or underinsured, whose annual income is equal to or less than the Federal Poverty Guidelines, as published and updated annually in the Federal Register, and who have no ability to pay for their medical care.

Medically Indigent patients include those patients who are capable for paying for their living expenses, but whose medical and hospital bills, after payment by third party payers, would require use or liquidation of income and/or assets critical to living or earning a living.

The identification of charity care begins at time of registration with the gathering information concerning third party payers and the patient's and guarantor's financial data and identification of community resources available to assist in paying the account. Generally, information will be gathered and potential community resources identified during the pre-admission process, where available, and while the patient is in Texas Rehabilitation Hospital of Arlington because access to the patient and family is greatest during that period. However, identification can occur at any time sufficient information is available to make the determination, including well after the normal collection cycle.

Classification of an account as charity care generally will end efforts to collect the accounts from the patient and, in most instances, from family members. Routine activity may continue in order to ensure that Texas Rehabilitation Hospital of Arlington can identify changed circumstances in the future and ensure continuity with respect to subsequent visits. Efforts to collect from third parties will continue, and any resulting collection would be a charity recovery. Classification of an account as charity care should not occur until:

- It is determined that in accordance with Item 2 above (determination of ability to pay based on variables), the patient and guarantor definitely do not have the financial resources to pay the account (or portions of the account), or in accordance with Item 7 below (approval by the CEO), treatment as charity is warranted under the circumstances determined by Texas Rehabilitation Hospital of Arlington in a manner consistent with how the partner Hospital makes charity care determinations.
- Even if an account is to be considered charity care under this policy, the patient and guarantor should receive at least one statement indicating the balance due on the account. They should also receive the routine follow-up statements and collection letters until such time as the charity care designation is made and it is determined that continuing such mailings will not result in collecting part or all of the account. These statements and collection letters should not indicate that the account is to be designated as charity care.
- It may be appropriate in some cases to notify a patient or guarantor that the account is classified as charity care, if doing so will enhance the public's understanding of Texas Rehabilitation Hospital of Arlington's charity care or assist in the collection of a portion of the account. If a patient or guarantor is to be notified that the account will be classified as charity care, the notification should be from a member of Texas Rehabilitation Hospital of Arlington management. (Exhibit 3).
- The charity care classification is authorized in accordance with Item 7 below.

Failure to provide information necessary to complete a financial assessment may result in a negative determination. A determination of eligibility for charity may be made without a complete assessment if eligibility is warranted under the circumstances as determined by Texas Rehabilitation Hospital of Arlington in a manner consistent with how the partner Hospital makes charity care determinations.

A charity care classification must be approved by the Controller and/or the CEO of Texas Rehabilitation Hospital of Arlington and approval shall be exercised in a manner consistent with how the partner Hospital approves charity care classifications.

No person shall be excluded from consideration for financial assistance based on race, creed, color, religion, sex, national origin, or physical disability. Only exclusion would be if the patient does not meet rehabilitation appropriateness.

This policy may not be terminated, modified or amended without approval of Texas Rehabilitation Hospital of Arlington Board of Managers. Texas Rehabilitation Hospital of Arlington Board of Managers may, from time to time, and to the extent not inconsistent with the terms and requirements of the Agreement, develop and adopt and require implementation of changes, modifications and amendments to this policy that it deems appropriate.

# EXHIBIT 1
## APPLICATION FOR FINANCIAL ASSISTANCE

| PATIENT INFORMATION | | | | |
|---|---|---|---|---|
| Patient Name | | Age | Telephone No. | Patient No. |
| Home Address<br><br>Rent ☐<br><br>Own ☐ | | | | Live with parents?<br>No ☐ Yes ☐ |
| SSN | Marital Status | Discharge diagnosis | | If pregnant, due date? |
| Name & Address of employer | | | Employer Telephone No. | How long employed? |
| Position/Title | | | Supervisor's Name | |
| If unemployed, last date & place of employment | | | Position/Title | |

| RESPONSIBLE PARTY INFORMATION | | | | |
|---|---|---|---|---|
| Name | Relationship to patient | | Age | Telephone No. |
| Street address, if different from patient | | | | |
| SSN | Marital Status | Family Size | Names & Ages | |
| Name & Address of Employer | | | How long employed? | Employer Telephone No. |
| Position/Title | | | Supervisor's Name | |
| If unemployed, last date & place of employment | | | Position/Title | |
| Name of Nearest Relative | | | | Relationship |
| Address | | | | Telephone No. |

| SPOUSE INFORMATION | | | | |
|---|---|---|---|---|
| Name | Age | SSN | | Name of Employer |
| Employer Address | | | How long employed? | Employer Telephone No. |
| Position/Title | | | Supervisor's Name | |
| If unemployed, last date & place of employment | | | | Position/Title |

| MONTHLY INCOME | | | | ASSETS | |
|---|---|---|---|---|---|
| **ITEM** | ☐ Patient ☐ Spouse ☐Father ☐ Mother | ☐ Patient ☐ Spouse ☐Father ☐ Mother | ☐ Patient ☐ Spouse ☐Father ☐ Mother | Checking Account(s) – bank & account number | Balance |
| Base Income | | | | | |
| Overtime | | | | Savings Account(s) – bank & account number | Balance |
| Social Security | | | | | |
| Interest/Dividends | | | | Other (bank & account number, money market, CD, IRA) | Balance |
| Rental Income | | | | | |
| Alimony/Child Support | | | | Life Insurance (company & policy number) | Value |
| Unemployment | | | | | |
| State Assistance | | | | Stocks, Bonds & Mutual Funds (company) | Value |
| Food Stamps | | | | | |
| Pension | | | | Automobiles/Trucks (make, model & year) | Value |
| Disability | | | | | |
| Worker's Compensation | | | | | |
| Other | | | | Other Assets (personal, livestock, machinery, motorcycles, RVs) | Value |
| | | | | Real Estate (list and describe) | Present Value |
| **TOTAL** | | | | **TOTAL ASSETS** | |

PLEASE COMPLETE THE INFORMATION AS THOROUGHLY AS POSSIBLE SO THAT AN ACCURATE ASSESSMENT OF YOUR CURRENT FINANCIAL SITUATION CAN BE DETERMINED. ALONG WITH THE FINANCIAL STATEMENT, AT LEAST TWO OF THE FOLLOWING ITEMS ARE REQUIRED FOR REVIEW. PLEASE PROVIDE THE FOLLOWING ITEMS:

1. **MOST RECENTLY FILED FEDERAL AND STATE INCOME TAX**
2. **BANK ACCOUNT STATEMENT (CHECKING AND SAVINGS; LAST THREE MONTHS)**
3. **VERIFICATION OF INCOME (PAYCHECK STUBS, UNEMPLOYMENT CHECK, SOCIAL SECURITY CHECKS, ETC)**

| MONTHLY EXPENSES | | OTHER EXPENSES | MONTHLY PAYMENT | BALANCE | PAYMENT CURRENT? |
|---|---|---|---|---|---|
| **ITEM** | **MONTHLY PAYMENT** | Charge Accounts | | | ☐ No ☐ Yes |
| Rent | | | | | ☐ No ☐ Yes |
| Mortgage | | | | | ☐ No ☐ Yes |
| Electricity | | | | | ☐ No ☐ Yes |
| Gas/Propane | | | | | ☐ No ☐ Yes |
| Water | | | | | ☐ No ☐ Yes |
| Refuse | | Personal Loan (name & purpose) | | | ☐ No ☐ Yes |
| Telephone | | | | | ☐ No ☐ Yes |
| Cable TV | | Automobile Loan (name) | | | ☐ No ☐ Yes |
| Food | | | | | ☐ No ☐ Yes |
| Clothing | | Real Estate Loan (name) | | | ☐ No ☐ Yes |
| Medicine | | | | | ☐ No ☐ Yes |
| Baby Sitter | | Cellular Phones/Pager | | | ☐ No ☐ Yes |
| Transportation | | | | | ☐ No ☐ Yes |
| Alimony/Child Support | | Miscellaneous (name & purpose) | | | ☐ No ☐ Yes |
| Auto Insurance | | | | | ☐ No ☐ Yes |
| Home Insurance | | | | | ☐ No ☐ Yes |
| Life Insurance | | **TOTALS** | **TOTAL MONTHLY PAYMENTS** | **TOTAL BALANCE** | |
| Health Insurance | | | | | |
| Personal Property Tax | | | | | |
| Real Estate Tax | | **SUMMARY** | | | |
| Sub-total | | | | | |

**Total Monthly Income** $_____

**Total Monthly Expenses** $_____

**Discretionary Income** $_____

**Monthly Payment Arrangements** $_____

**OTHER EXPENSES**

Will the patient be unable to work or go to school due to physical impairment? ☐ No ☐ Yes

If yes, what is the disabling condition or diagnosis? _____

How long will the patient be disabled? _____

(Please attach a statement from the doctor.)

**COMMENTS**

**PATIENT AGREEMENT**

The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The original or a copy of this application will be retained by the creditor, even if financial assistance is not granted. The undersigned also agrees to allow this facility to contact any or all of the above references for credit verification, including credit bureaus.

_____

**Patient Signature**

_____

**Responsible Party or Spouse Signature**

_____

**Facility Representative Department**

_____

**Date**

# EXHIBIT 2

Date: _____

Patient Name: _____

Account Number: _____

Admission Date: _____ Discharge Date: _____

Estimated Insurance Liability $_____ Account Balance: $_____

Total Amount Due $ _____

Dear _____:

Attached you will find a financial assistance application form. Financial assistance is based on current balances. If you qualify for any financial assistance, payments already made to this account will not be refunded. Please fill out the application completely and provide me with the following indicated support documents within two (2) weeks:

_____ Last year's federal tax return with W-2, W-2G, or 1099-R forms and support schedules.

_____ Proof of income (i.e., check stubs, Social Security Benefits, etc.).

_____ Bank statements for the past three (3) months.

The financial statement must be signed by the guarantor and the guarantor's spouse, if applicable.

Thank you for your anticipated cooperation in gathering the information needed for the application. Please be aware that if all information is not received, your application for assistance will not be processed.

Your account will be kept open for two (2) weeks pending the return of the above information. If you have any questions, please call toll-free at (888) 545-6555, ext. 2718, Monday through Friday, 8:30 a.m. to 4:30 p.m.

Sincerely,

Mike Bradshaw
Director, Patient Accounts
Enclosures

# EXHIBIT 3

Date: _____

Patient Name: _____

Account Number: _____

Dates of Service: _____

_____ Your application for financial assistance has been approved in the amount of _____%. This allowance will be applied to Texas Rehabilitation Hospital of Arlington charges remaining after all applicable insurance benefits have been paid. This allowance does not apply to your physician's bill or non-covered items such as private room, take home items, etc. The balance remaining, after financial assistance has been applied, must be paid by cash, personal check or money order. Please contact the Patient Accounts Department regarding your choice of payment options.

Your current balance after financial assistance is $: _____.

_____ Your application for financial assistance has been denied. Your level of income is higher than the standard level used to compute our financial assistance allowance.

Sincerely,

Patient Accounts Department
Monday – Friday (8:30 a.m. to 4:30 p.m.)