FBCHHS INTERNAL POLICY AND PROCEDURE

Policy Title: Financial Assistance Program and Charity Care Policy

1. POLICY STATEMENT

Fort Bend County Health & Human Services (FBCHHS) is committed to providing high quality and equitable Public Health Services. The financial circumstances of those in need of health services should not be a barrier to seeking or receiving services. It is the policy of FBCHHS to not deny medically necessary services due to a person's inability to pay. Therefore, FBCHHS through the Financial Assistance Program and Charity Care Policy (FAP-CCP) offers charity care assistance to cover the cost of applicable services to eligible Fort Bend County residents seen at any of its service locations regardless of age, sexual orientation, race, national origin, religious affiliation, or socio-economic status.

FBCHHS' mission is to promote and protect the health and well-being of Fort Bend County residents through disease prevention and intervention. Any patient receiving assistance under FBCHHS FAP-CCP will not be charged for the health services they receive.

2. POLICY PURPOSE

This policy establishes the criteria to determine patient eligibility for the FBCHHS FAP-CCP in compliance with Rule §355.8215 of the Texas Administrative Code and all applicable sections of state and federal laws, as well as to overlay additional agency policy and procedures in the administration/implementation of the FBCHHS FAP-CCP.

3. SCOPE AND APPLICATION

This Policy is applicable to all FBCHHS service locations, including all Annexes and Mobile Clinics, providing public healthcare services. Accordingly, this written policy:

- Includes eligibility criteria for financial assistance.
- Describes the client's responsibility for verification of eligibility.
- Describes how this policy will be advertised and presented to clients.
- Explains the record retention of supporting documentation.

FAP-CCP is authorized under Section 1115 of the Social Security Act, also known as the 1115 waiver. In accordance with the Special Terms and Conditions of the 1115 waiver, to participate in the program, providers must be funded by a unit of government able to certify public expenditures. The following provides the eligibility criteria for providers:

In accordance with the Texas Health and Safety Code Chapter 533 and 534, the following entities providing behavioral health services are eligible to participate:

- Community Mental Health Clinics (CMHCs)
- Community Centers
- Local Behavioral Health Authorities (LBHAs)
- Local Mental Health Authorities (LMHAs)

Date Issued: Enter a date.
Date Last Reviewed: 9/6/2024
Date Last Revised: 9/6/2024

In accordance with Title 2 Texas Health and Safety Code Chapter 121, the following entities established under Chapter 121 are eligible to participate:

- Local Health Departments (LHDs)
- Public Health Districts (PHDs)

This policy goes into effect Year 3 (DY13) which is FBC County fiscal year 2024 beginning October 1, 2023. FBCHHS will create a revenue allocation that will authorize diversion of revenue from the Public Health Provider - Charity Care Program (PHP-CCP) for the purpose that support FBCHHS as defined in this policy.

4. DEFINITIONS

Term	Definition
Charity Care	Healthcare services that have been or will be provided but are never expected to result in cash inflows. Charity care provides healthcare services for free, or at a discount, to individuals who meet the established criteria.
Family	Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.
Family Income	Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines: • Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources; • Noncash benefits (such as food stamps and housing subsidies) do not count; • Determined on a before-tax basis; • Excludes capital gains or losses; • If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).
Federal Poverty Level (FPL)	The applicable household income thresholds established periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C.~9902(2).
Financial Assistance	Is the cost of providing free medical service(s) to individuals who are uninsured or underinsured and cannot afford to pay for the service(s).

Public Health Services	Services designed to protect and promote the general population's health and to prevent higher-cost interventions such as hospitalizations. These services include but are not limited to tuberculosis identification, diagnosis, and treatment; sexually transmitted disease identification, diagnosis, and treatment; immunization (clinical services and administration); dental care; and chronic disease screening, monitoring, and self-management.
Qualifying Provider	Title 2 Texas Health and Safety Code Chapter 121 provides the authority to Local Health Departments. Fort Bend County Health and Human Services is a local health department.
Uninsured	The patient has no level of insurance or third-party assistance to assist with meeting his/her payment obligations.
Underinsured	The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed their financial abilities.

5. POLICY DETAILS

I. Overview

The FBCHHS Financial Assistance Program and Charity Care Policy (FAP-CCP) extends to uninsured clients who qualify on the criteria listed in section II of this policy. Uninsured clients who meet one or more of the eligibility criteria listed in Section II of this policy shall receive public health services at no charge at all FBCHHS locations (including mobile clinics). Only services provided by FBCHHS are covered by this policy.

II. Eligibility Criteria for Clients

Qualification for Financial Assistance Program and Charity Care Policy (FAP-CCP) shall be based on an individualized determination of financial need and shall not consider age, gender, race, ethnicity, sexual orientation, or religious affiliation.

Only uninsured clients are eligible for the Financial Assistance Program and Charity Care Policy (FAP-CCP). Individuals with private health insurance and public coverage insurance options such as Medicare and Medicaid do not qualify for Financial Assistance Program and Charity Care Policy (FAP-CCP) and are considered insured.

An uninsured patient is eligible for the Financial Assistance Program and Charity Care Policy (FAP-CCP), and a 100% discount for services provided by FBCHHS at any service location, including mobile clinics, if they meet one or more of the following financial criteria:

a) Household income at or below the 400% of the Federal Poverty Level Guidelines.

Persons in family/household	Poverty Guideline	400% of the FPL
1	$15,060	$60,240
2	$20,440	$81,760
3	$25,820	$103,280

4	$31,200	$124,800
5	$36,580	$146,320
6	$41,960	$167,840
7	$47,340	$189,360
8	$52,720	$210,880
For families/households with more than 8 persons, add $5,380 for each additional person.		

Source: *https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines - 2024 poverty guidelines are in effect as of January 17, 2024. Federal Register Notice, January 17, 2024 (PDF)*

b) Experiencing homelessness
c) eligible for Medicaid at time of service, but do not have Medicaid at the Date of Service
d) eligible for participation in in Women, Infants and Children programs (WIC)
e) eligible for food stamps (SNAP/Lone Star Card/EBT)
f) eligible for another need-based federal, state, or local assistance program
g) eligible for rent voucher from federal/state, housing authority
h) lack of money to pay for needed clinical services.
i) other conditions which, in the discretion of the Director, are consistent with the purposes, intent and terms of The Policy and comply with applicable law.

III. Eligibility Verification

All persons receiving public health services at FBCHHS will complete a Financial Assistance Program and Charity Care Screening Form (Attachment A). The screening form will determine if the patient qualifies for Financial Assistance. Proof of asserted financial hardship is not required. If proof of financial hardship is presented, a copy will be made and the copy will be retained in the patient's medical record. The original document will be returned to the patient.

IV. Inability to Pay Qualification

Per the Texas Administrative Code (Sec. 121.006. Public Health Services Fees) any person receiving public health services at FBCHHS may not be denied services for inability to pay. Individuals who cannot pay the assigned fee for service due to financial hardship shall receive the service free of charge, and no bill shall be issued for the rendered service.

V. Community Communication Plan

FBCHHS Financial Assistance Program and Charity Care Policy (FAP-CCP) is readily available to any person seeking public health services at any of the FBCHHS service locations. Information on the FBCHHS FAP-CCP is also available on the FBCHHS website (insert link) and posters are conspicuously posted in waiting rooms and communicated through FCBHHS health education and community outreach. Information is available in (list languages). Copies of the policy are available for review by the clients upon request. Written notice of the policy is provided to clients during the eligibility process.

VI. Records Retention

The FBCHHS Financial Assistance Program and Charity Care Screening Form and all supporting documentation will be maintained with the patient's medical records in accordance with Fort Bend County's Record Management Policy (insert link).

The medical records retention schedule will be used for the Financial Assistance Program and Charity Care Screening Form and all supporting documentations, or the appropriate financial Texas State Library and Archives Commission retention period – whichever is longer. (insert Library archive link here).

VII. Participating Providers

This policy is inclusive of the following public health services at FBCHHS, which operate under the medical authority of the Local Health Authority of Fort Bend County:

a) STD/HIV Clinic
b) Tuberculosis Clinic
c) Immunization Clinic
d) Community Health & Wellness
   - Chronic Disease Screenings
   - Mental Health Services

Eligibility Requirements and Verification per TAC 355.8217:

Requirement	Verification
Indicate it is a qualifying provider	Fort Bend County Health and Human Services is the Local Health Department of Fort Bend County, as established by the Texas Health and Safety Code, Chapter 121.
Attend PHP-CCP financial training and receive credit	Designated FBCHHS staff shall attend all required trainings.
Submit annual PHP-CCP cost report	Designated FBCHHS staff shall complete the PHP-CCP cost report with required certifications in accordance with and the manner specified by HHSC, and within HHSC timeline.
Certify that no part of the FAP-CCP payment will be used to pay a contingency fee.	No part of the FAP-CCP payment is used for a contingency fee.

See FBCHHS List of Participating Providers in Attachment B. This list is also available online at the following link (insert link).

6. PROCEDURES

I. Application Process

All clients that visit any FBCHHS service locations are provided with the FBCHHS Financial Assistance Program and Charity Care Screening Form (Attachment A) to be completed during the registration process. In instances where a client does not complete the form or returns an incomplete form and was provided services, FBCHHS staff may provide the client's name and include that the client refused to sign on the form. FBCHHS staff should make every attempt to contact the client to verify the form information.

II. Income Verification

The screening form will determine if the patient qualifies for Financial Assistance. Proof of asserted financial hardship is not required. If proof of financial hardship is presented, a copy will be made and the copy will be retained in the patient's medical record. The original document will be returned to the patient.

III. Cost Reporting

FBCHHS will prepare and complete the Public Health Provider Cost Report on an annual basis to report and request reimbursement on uncompensated care only. Cost reports must be submitted no later than 45 days after the close of the reporting period (October 1st through September 30th). Costs are eligible for reimbursement for up to 24 months after the date the cost was incurred.

FBCHHS may request reimbursements for uncompensated services provided in any of the FBCHHS service locations. The determination of the amount of reimbursement Health & Human Services Commission (HHSC) for the Charity Care Program (CCP) is based on a formula issued by HHSC.

The cost report will be prepared by FBCHHS Deputy Director or designee and notarized prior to submission. Completed costs reports are submitted via File Transfer Protocol (FTP) and subsequently emailed to HHSC Provider Finance Department at PHP-CCP@hhs.texas.gov.

Elements of Cost Report include but not limited to:

- **Cost Report Cover Page** – it includes FBCHHS National, and State Provider Identification Number used by HHSC to obtain the fee-for-service cost date included in the cost report.
- **General and Statistical Information** – this includes general provider information and statistical information.
- **Direct Medical** – this identifies and summarizes all service costs within the cost report from other documents. It provides a sum of personnel expenses and adds additional costs to calculate the total cost of medical and uncompensated care services.
- **Cost Report Certification** – this attest to and certifies the accuracy of the financial information contained within the cost report. This form must be notarized.
- **Certification of Funds** – this is the certification of public expenditure. This form attests to and certifies the accuracy of the financial information provided, the report was prepared in accordance with State and Federal audit and cost principle standards, the costs have not been claimed on any other cost report for federal reimbursement purposes. This also identifies the amount of local provider expenditure allowable for use as State match.
- **Schedule A (Depreciation Schedule)** – this identifies depreciable assets for which there was a depreciation expense during the cost report period.
- **Schedule B (Payroll and Benefits)** – this includes salary and benefits and appropriate reductions related to FBCHHS staff for uncompensated care.
- **Schedule C (Cost Allocation Methodologies)** – this will include detailed cost allocation methodologies.

7. FORMS

- Attachment A. Charity Care Screening Form
- Attachment B. List of Providers
- Attachment C. FBCHHS Charge Master
- Attachment D. Financial Assistance Program and Charity Care Policy Communications Flyer
- Attachment E. Commissioner Court Policy Approval and Action Item for Diversion of Revenue Approval

8. RESPONSIBILITIES

Position or Office	Responsibilities
Local Health Authority	FBCHHS Director is Fort Bend County's Local Health Authority
Deputy Medical Director	Clinical oversight, regulatory compliance, and policy governance
Deputy Director	Cost Reporting and Financial Assistance Program management

9. RELATED INFORMATION

FBCHHS shall comply with all other federal, state, and local laws, and regulations that may apply to activities conducted under this policy. These include, but are not limited to:

1. Texas Administrative Code, Title 1 Administration, Part 15 Texas Health and Human Services Commission, Chapter 355 Reimbursement Rates, Subchapter A Cost Determination Process
2. Texas Administrative Code, Title 1 Administration, Part 15 Texas Health and Human Services Commission, Chapter 355 Reimbursement Rates, Subchapter J Purchased Health Services Division 11 Texas Healthcare Transformation and Quality Improvement Program Reimbursement, Rule §355.8215 Public Health Provider - Charity Care Program (PHP-CCP)
3. https://pfd.hhs.texas.gov/acute-care/public-health-provider-charity-care-program

10. CONTACTS

Please direct any questions regarding this policy to:

Office	Phone	Email
Operations, Finance & Social Services (OFS)	(281) 238-3233	Ketan.Inamdar@fortbendcountytx.gov

11. POLICY URL

- (Insert link here)

12. REVIEW & APPROVAL

Legal Review Date		Auditor Review Date	
		SHughes	09/16/2024
Executive Signature	**Print Name**		**Date**
	Letosha Gale Lowe		09/16/2024

FORTBEND
HEALTH & HUMAN SERVICES
Prevent. Promote. Protect.

Financial Assistance and Charity Care Application

Aplicación para el Programa de Asistencia Financiera y Ayuda Caritativa

Applicant Information/ Información del Solicitante				
Applicant's First Name *Primer nombre del solicitante*	**Middle Name** *Segundo Nombre*		**Last Name** *Apellido*	
Date of Birth / *Fecha de nacimiento*	**Sex at Birth/** *Sexo al nacer*	☐ Male / *Masculino*	☐ Female / *Femenino*	
____ / ____/ _____	**Gender** / *Genero*	☐ Man/ *hombre*	☐ Woman/*mujer*	
	☐ Trans male *hombre transgénero*	☐ Trans female *mujer transgénero*	☐ Non-binary/gender non-conforming *No-binario/ genero no conforme*	
Home Phone Number/ *Números de casa*	**Cell** / *Celular*		**Email Address** /*Correo electrónico*	
Employment Status/ *Estatus de empleo*	☐ Employed/*empleado*	☐ Unemployed/*desempleado*	☐ Disabled/ *deshabilitado*	
	☐ Self-Employed/ *autónomo*	☐ Student/ *estudiante*	☐ Retired/ *retirado*	
Marital Status /*Estado Civil*	☐ Single/*soltero*	☐ Married/*Casado*	**Are you a veteran?** *¿Eres un veterano?*	
	☐ Divorced/*divorciado*	☐ Widow/ *viudo*	☐ Yes/*Si*	☐ No/*No*
Mailing Address (Street or P.O Box) *Dirección (Calle o P.O Box)*	**City** *Ciudad*	**County** *Condado*	**State** *Estado*	**ZIP** *Código Postal*

Household Information / ***Información del Hogar***

Household includes: Applicant Patient, Spouse (including same-sex marriage recognized by U.S. Jurisdictions), Children up to age 18 or up to age 21 if a high school or college student, Elderly patients that are dependent on their children for support and are claimed as a dependent on their income taxes.

Hogar incluye: Paciente/solicitante, cónyuge (incluyendo el matrimonio entre personas del mismo sexo reconocidas por jurisdicciones de Estados Unidos), Niños hasta los 18 años o hasta 21 años si están en la escuela secundaria o estudiantes universitarios, Pacientes de edad avanzada que dependen de los hijos para el apoyo y son reclamados como dependiente en sus impuestos.

Fill in line (1) with your information. Fill in the remaining lines for those who live in the household for which you are legally responsible.
Llene la primera línea con Información acerca de usted mismo. Llene las líneas restantes acerca de todos que viven con usted, y es legalmente responsable.

Name (Last, First, Middle) *Nombre (Apellido, Primera, Segundo)*	**Relationship to you?** *¿Cuál es la relación a usted?*	**Date of Birth** *Fecha de nacimiento*	**Age** *Edad*	**Sex** *Sexo*	**Race** *Raza*	**Ethnicity** *Etnicidad*	**SSN Number** *No. de Seguro Social*
(1)	**Self** *Yo mismo*						
(2)							
(3)							
(4)							

Race/Raza		**Ethnicity / Etnicidad**
W – White /Blanca	**MOR** – More Than One Race /Más De Una Raza	**LH** – Latino or Hispanic/ Latino ò Hispano
B – Black /Negro	**U** – Unreported /Unknown /No Declarada/Desconocida	
A – Asian /Asiático	**NH** – Native Hawaiian /Nativo de Hawái	**NH** – Not Hispanic/ No Hispano
OPI – Other Pacific Islander/ de otras islas del Pacífico	**NA** – American Indian / Alaskan Native/ Indio Americano / Nativo de Alaska	

Created 9/5/25.

List All of the Household's Income below / *Liste los ingresos de cada miembro familiar abajo:*			
Name of Person Receiving Income *Nombre de la persona que recibe ingresos*	**Source of the Income** *Fuente del Ingreso*	**Amount Received** *Cantidad Recibida*	**How often is the income received?** (Daily, Weekly, Every two weeks, twice a month, monthly?) *¿Con qué frecuencia recibe el ingreso? (Diariamente, por semana, cada quincena, mensual*)
(1)			
(2)			
(3)			
(4)			

Does anyone in the Household have Health Insurance? *¿Alguien en el hogar tiene seguro de salud?*	☐ Yes/*Si*	☐ No/ *No*

Name of Person Insured *Nombre de la persona que tiene seguro de salud*	**Name of Insurance** *Nombre de seguro*	**Policy ID** *Número de identificación de la póliza*
(1)		
(2)		
(3)		
(4)		

The statements I have made, including my answers to all questions, are true and correct to the best of my knowledge. I agree to provide Fort Bend County Health & Human Services (FBCHHS) staff with any information necessary to prove statements about my eligibility.

I understand that this application will be considered without regard to race, color, religion, creed, national origin, age, sex, disability, or political belief; and that I may request a review of the decision made on my application.

Las declaraciones que he hecho, incluyendo mis respuestas a todas las preguntas, son verdaderas y correctas de acuerdo a mis conocimientos. Estoy de acuerdo en dar al personal/empleados del Departamento de Salud y Servicios Humanos del Condado Fort Bend (FBCHHS por sus siglas en inglés) cualquier información necesaria para comprobar mis declaraciones sobre la elegibilidad.

Entiendo que esta aplicación será considerada sin distinción de raza, color, religión, credo, origen nacional, edad, sexo, discapacidad o creencia política; y que puedo solicitar una revisión de la decisión tomada sobre mi solicitud o recertificación de asistencia.

Application Signature
Firma del Solicitante

Date
Fecha