City of Laredo Public Health Department
Public Health Provider-Charity Care Program
Financial Assistance Policy-Charity Care

Policy Statement

The City of Laredo Public Health Department (CLPHD) is committed to providing high-quality and equitable public health services to all residents, with a focus on serving underserved and vulnerable populations. The financial circumstances of those in need of care should never be a barrier to seeking or receiving medically necessary services.

In alignment with the Texas Health and Human Services Commission (HHSC) Public Health Providers – Charity Care Program (PHP-CCP) Protocol and the Centers for Medicare & Medicaid Services (CMS) guidelines, CLPHD ensures that any patient who qualifies for financial assistance under this policy will not be charged for eligible services during the approved assistance period.

Our mission is to prevent disease, disability, and premature death, promote healthy lifestyles, and protect the health and quality of the environment for all residents of Laredo. Through the Charity Care Program, we reaffirm our commitment to accessible, patient-centered care that prioritizes community health and equity

This policy is effective October 1, 2025, and remains in effect until amended or superseded. The effective date is on or before the start of the applicable cost reporting period for compliance with HHSC PHP-CCP requirements.

Charity Care Program Policy

The City of Laredo Public Health Department (CLPHD) is committed to ensuring that financial circumstances do not prevent access to essential health services. This policy provides financial assistance to uninsured, underinsured and underserved patients who meet the eligibility requirements outlined in Section (Eligibility) of this policy. Patients who qualify will receive clinical services at no charge or discounted fees at CLPHD clinics.

Eligibility for financial assistance will be determined through an individualized assessment of financial need and will not take into account a patient's age, gender, race, ethnicity, socio-economic status, sexual orientation, or religious affiliation. All applicants must provide proof of household income and Texas residency at the time of application.

Only services provided directly by the CLPHD are covered under this policy. The policy:

1. Defines eligibility criteria for financial assistance.

2. Outlines the patient's responsibility for providing documentation to verify eligibility.
3. Describes how the policy will be communicated and made available to patients.
4. Explains the record retention requirements for supporting documentation.

Through this Charity Care Policy, the CLPHD reaffirms its commitment to equitable access to health care for the underserved and vulnerable populations of Laredo

Regulatory Requirements

In implementing this The City of Laredo Public Health Department commits to compliance with all other federal, state, and local laws, rules, and regulations that may apply to the activities conducted pursuant to this Policy. This policy is designed to comply with TAC 355.101-107, 355.110, 355.8217 and all associated regulatory requirements

Eligibility Criteria

Financial assistance under this policy will be granted based on household income in relation to the current Federal Poverty Guidelines (FPG), adjusted for household size. The City of Laredo Public Health Department uses the following Sliding Fee Scale (SFS) to determine eligibility for discounts:

Family Size	Federal Poverty	100% Discount (≤ 250% FPG)	75% Discount (251–300% FPG)	50% Discount (301–350% FPG)	25% Discount (351–400% FPG)	Not Eligible (>400% FPG)
1	$15,650	≤ $39,125	$39,125.01 – $46,950	$46,950.01 – $54,775	$54,775.01 – $62,600	> $62,600
2	$21,150	≤ $52,875	$52,875.01 – $63,450	$63,450.01 – $74,025	$74,025.01 – $84,600	> $84,600
3	$26,650	≤ $66,625	$66,625.01 – $79,950	$79,950.01 – $93,275	$93,275.01 – $106,600	> $106,600
4	$32,150	≤ $80,375	$80,375.01 – $96,450	$96,450.01 – $112,525	$112,525.01 – $128,600	> $128,600
5	$37,650	≤ $94,125	$94,125.01 – $112,950	$112,950.01 – $131,775	$131,775.01 – $150,600	> $150,600
6	$43,150	≤ $107,875	$107,875.01 – $129,450	$129,450.01 – $151,025	$151,025.01 – $172,600	> $172,600
7	$48,650	≤ $121,625	$121,625.01 – $145,950	$145,950.01 – $170,275	$170,275.01 – $194,600	> $194,600
8	$54,150	≤ $135,375	$135,375.01 – $162,450	$162,450.01 – $189,525	$189,525.01 – $216,600	> $216,600

9	$59,650	≤ $149,125	$149,125.01 – $178,950	$178,950.01 – $208,775	$208,775.01 – $238,600	> $238,600
10	$65,150	≤ $162,875	$162,875.01 – $195,450	$195,450.01 – $228,025	$228,025.01 – $260,600	> $260,600
11	$70,650	≤ $176,625	$176,625.01 – $211,950	$211,950.01 – $247,275	$247,275.01 – $282,600	> $282,600
12	$76,150	≤ $190,375	$190,375.01 – $228,450	$228,450.01 – $266,525	$266,525.01 – $304,600	> $304,600
13	$81,650	≤ $204,125	$204,125.01 – $244,950	$244,950.01 – $285,775	$285,775.01 – $326,600	> $326,600
14	$87,150	≤ $217,875	$217,875.01 – $261,450	$261,450.01 – $305,025	$305,025.01 – $348,600	> $348,600
15	$92,650	≤ $231,625	$231,625.01 – $277,950	$277,950.01 – $324,275	$324,275.01 – $370,600	> $370,600

Discount eligibility decreases as income exceeds poverty guidelines.

Eligibility Validation and Verification

All persons requesting assistance through the City of Laredo Charity Care Program must complete a Financial Assistance Program and Charity Care Screening Form (Attachment A). The screening form will determine if the patient qualifies for Charity Care under this policy. Proof of asserted financial hardship is not required. However, if proof of financial hardship is presented, a copy will be retained with the medical record and the original returned to the patient. Examples of financial hardship include but not limited to, loss of family member, loss of job, bankruptcy, debilitating disease, care giver for family members.

In determining eligibility, CLPHD may consider:

- Household assets and net worth
- Employment status
- Outstanding medical bills or other significant financial obligations
- Other financial resources available to the patient

CLPHD may also verify information using publicly available data, Medicaid enrollment status, or other reasonable methods. If complete financial information is unavailable, eligibility decisions will be made based on the best available evidence in accordance with HHSC PHP-CCP guidelines.

Eligibility determinations will be documented in the patient's record and reviewed annually or sooner if household circumstances change.

Who Can Apply for the Charity Care Program

Any uninsured, underinsured, or underserved resident of Texas who meets the financial eligibility requirements set forth in this policy may apply. Eligibility is determined without regard to age, gender, race, ethnicity, socio-economic status, sexual orientation, or religious affiliation. Applicants must be Texas residents and must be seeking services provided directly by the CLPHD or its participating providers.

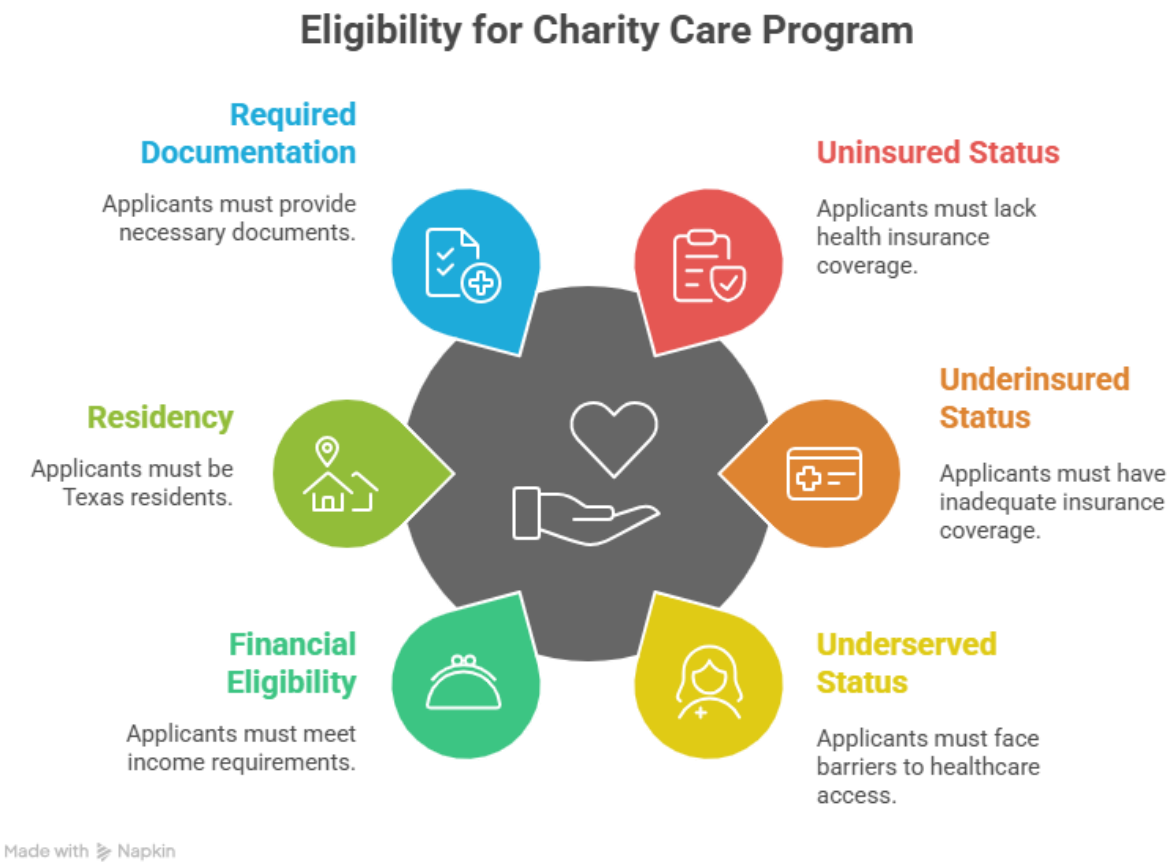
Required Documentation

Applicants must submit documentation sufficient to verify household income, residency, and any other factors relevant to determining eligibility.

Acceptable documentation includes:

- Recent pay stubs
- Most recent federal tax return
- Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) award letters
- Unemployment benefit statements

- Other official benefit determination letters
- Signed self-declaration of income form if other documents are unavailable



Application Process

Applications may be submitted in person at any CLPHD clinical service location, via mail to the CLPHD Administrative Office, or electronically through the CLPHD website when available. All applicants must complete the **F**inancial Assistance Program and Charity Care Screening Form (Attachment A). Staff are available on-site to assist with completing the form and to answer any questions regarding required documentation.

Point of Contact

Applicants may contact the CLPHD Charity Care Program Coordinator at:
City of Laredo Public Health Department
2600 Cedar Ave

Phone: **956-795-4900**
Email: clhd@ci.laredo.tx.us

Processing Timeline

The CLPHD will review and process completed applications within **10 business days** of receipt. Applicants will receive written notification of approval or denial, including the effective date and duration of eligibility. Incomplete applications will be returned with a request for additional information.

Participating Providers

The following CLPHD-operated clinics and laboratories participate in the Charity Care Program and have agreed to provide covered patient care services. Additional clinics may be added through formal amendment of this policy:

- Primary Care
- Lifestyle Medicine

Record Retention

Charity Care Screening Forms and supporting documentation will be retained as part of the patient's medical record in accordance with the City of Laredo Public Health Department's Record Retention Policy. Per HIPAA (45 CFR §164.316), all required documentation must be maintained for at least six years from the date of creation or last effective date, unless state law requires a longer period. HIPAA requirements take precedence over shorter state retention timelines.

Community Communication Plan

The City of Laredo Charity Care Policy is available through posted notices in all clinical service and registration areas. Copies of the policy are available for review by the patient upon request. Written notice of the policy is provided to patients during the registration process.

Charity Care and Uninsured Related Definitions

Uninsured: An individual who has no health insurance or other source of third-party coverage for medical/health services.
Uninsured Cost: Uninsured Cost is the cost to provide services to uninsured patients as defined by the Centers for Medicare and Medicaid Services (CMS). HHSC considers an individual whose third-party coverage does not include the service provided to be uninsured for that service.

Underserved: is a person who has limited or no adequate access to essential health care services due to factors such as income, geographic location, insurance status, or other social and economic barriers.

Charity Care: Healthcare services provided without expectation of reimbursement to uninsured patients

Attachment A

Financial Assistance Program and Charity Care Screening Form

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION
Has the Patient applied for Charity Care Before?□ **Yes** □ **No**If yes date applied:
Patient Uninsured? □ **Yes** □ **No**
Has the patient applied for Medicaid? □ **Yes** □ **NoMay be required to apply before being considered for Charity Care assistance**

Check below if any of the Financial Hardship criteria applies to you:

- □ Experienced homelessness
- □ Filed personal bankruptcy in federal court
- □ Eligible for participation in Women, Infants and Children programs (WIC)
- □ Eligible for food stamps (SNAP/Lone Star Card/EBT)
- □ Eligible for rent voucher from federal/state, housing authority or City
- □ Residence address is subsidized housing
- □ Household income at or below 400% of the then-current Federal Poverty Guidelines

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PATIENT AND APPLICANT INFORMATION			
Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (specify_____)	Birth Date		Social Security Number (optional*)
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional*)
Mailing Address -_____ _____ City State Zip Code			Main contact number(s)_____ ( )_____ ( )_____ Email Address:

Financial Assistance Program and Charity Care Screening Form

Employment status of person responsible for paying bill

□ **Employed** (date of hire:_____) □ Unemployed (how long unemployed:_____)
_□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

FAMILY HOUSEHOLD SIZE AND INCOME INFORMATIO

Provide number of family members in your household (related by birth, marriage, and adoption) AND Income information.

FAMILY SIZE_____List the applicant's household income below.

Name of Household Member Receiving money	Name of Agency Person or Employer who provides Money	Type of Income	Amount Received	How Often Received	Monthly Income Total
		Total Countable Monthly Income			

PATIENT AGREEMENT

I understand that the City of Laredo Health Department may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for Charity Care Assistance.

By signing below, I certify that

1. The above information is true and correct to the best of my knowledge **AND**
2. One or more of the financial hardship criteria listed in this application applies to me **AND**
3. I do not have Health Insurance Medicare or Medicaid

_____

Applicant Name

_____

Guardian Name (if applicable)

_____- _____

Signature Date