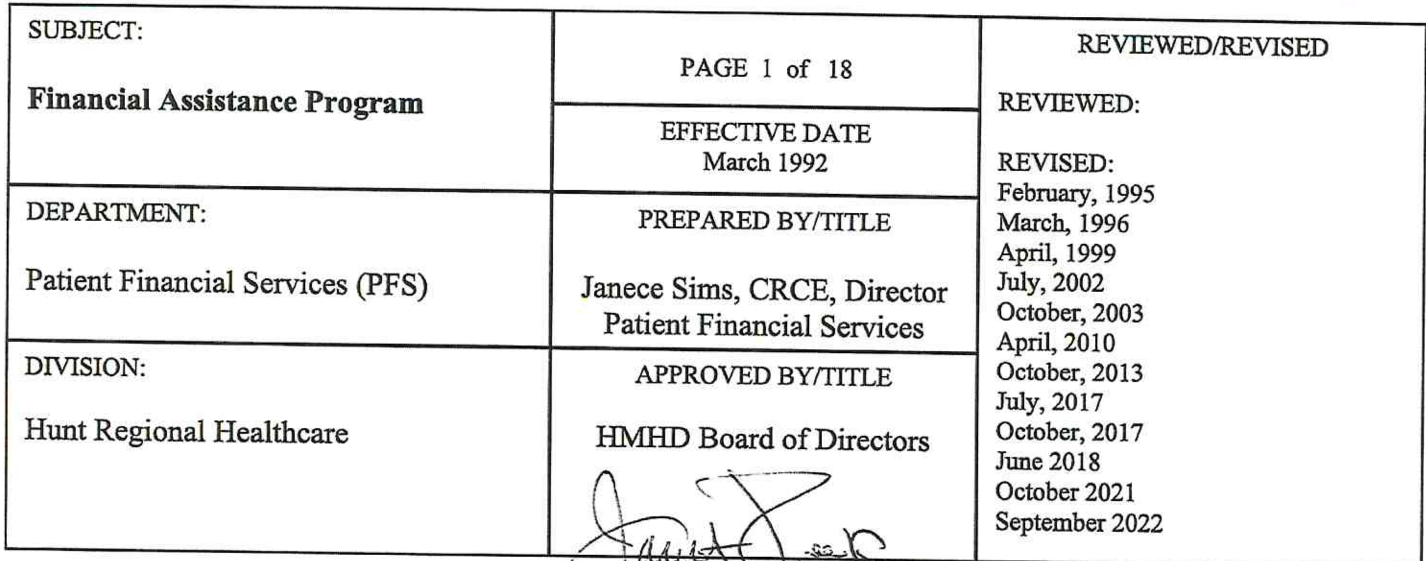
HUNT MEMORIAL HOSPITAL DISTRICT

POLICY/PROCEDURE



SUBJECT: **Financial Assistance Program**	PAGE 1 of 18	REVIEWED/REVISED
	EFFECTIVE DATE March 1992	REVIEWED:
DEPARTMENT: Patient Financial Services (PFS)	PREPARED BY/TITLE Janece Sims, CRCE, Director Patient Financial Services	REVISED: February, 1995 March, 1996 April, 1999 July, 2002 October, 2003 April, 2010
DIVISION: Hunt Regional Healthcare	APPROVED BY/TITLE HMHD Board of Directors	October, 2013 July, 2017 October, 2017 June 2018 October 2021 September 2022

Financial Assistance Program

Purpose

1.0 To ensure that a systematic process exists for the provision of medically necessary care to uninsured and under-insured Hunt County residents who have documented limited resources to pay the Hunt Memorial Hospital District (HMHD) usual and customary charges.

Policy

2.0 Recognizing the medical needs of our uninsured and under-insured population, Hunt Memorial Hospital District provides necessary quality medical care regardless of race, creed, color, sex, national origin, sexual orientation, physical ability, age or ability to pay to eligible residents of Hunt County.

2.1 In keeping with the District's commitment to serve all members of its community, a Financial Assistance Program will be considered for Hunt County Residents in situations where the clinical need for care and the inability to pay co-exist.

2.2 Under this policy, reimbursement and services for the care of any patient will be based on medical necessity and may be subject to limited visits within our outpatient Therapy Services department, if applicable. The policy excludes consideration for elective services, hospital durable medical equipment and supplies.

2.2.1 If medical necessity is in question, a clinical case review may be warranted and completed by either the Chief Medical Officer, Chief of Staff and/or a relevant physician.

2.2.2 The purpose of such review is to determine if the case is medically necessary or considered elective.

2.2.3 Should a clinical case review be warranted, it should not be completed by the ordering physician.

2.2.4 Guidelines followed are specified in the Texas Health and Human Services Commission (HHSC) manual and/or the County Indigent Health Care Program (CIHCP) handbook.

2.2.5 Medicaid and Medicaid HMO charges that are *"not a benefit"* or *"non-covered"* will be adjusted off of the patient's claim and deemed charity without any asset or income verification. The patient will not receive a bill.

2.3 Eligibility for financial assistance is determined, in part, by comparing a family's net income to the Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services (HHS), at two hundred percent (200%) of the then current guidelines (**Attachment D**). We will also use other resources and assets to determine eligibility for the program.

2.3.1 Once eligibility for Financial Assistance is approved, the write-off amount on each account is 100% and will be credited on the patient account.

2.3.2 HMHD will not pursue collection efforts on qualified applications.

2.4 HMHD has the authority to make case-by-case determinations based on administrative discretion.

Scope

3.0 This policy applies to Hunt Memorial Hospital District (HMHD).

Procedure

4.0 Eligibility

4.1 Applicant must be a resident of Hunt County on or before the date of service.

4.2 A VALID Texas Driver's License or other official photo identification with a current Hunt County address should be provided before processing the application.

4.2.1 If current DL/ID does not list a Hunt County address, the applicant should provide two forms of residency within Hunt County at the time of service.

4.2.2 Refer to http://www.txdps.state.tx.us/driverlicense/ for additional information regarding a Driver's License change of address or renewal.

4.3 Applicant shall meet the HMHD basic income and resources requirements, including a family income shall be equal to or less than two hundred percent (200%) of the current Federal Poverty Guidelines established by Texas Health and Human Services Commission (HHSC).

4.4 Applicant must be a U.S. Citizen or in the U.S. legally.

4.4.1 Student VISAs are accepted

4.4.2 U.S. Permanent Residency Identification Card is accepted

4.4.3 Visiting permits are not accepted

4.4.4 A letter from Immigration and/or an attorney stating their application has been accepted.

4.5 Applicant must have a current account for services provided within the past three (3) months at HMHD or have a current physician's order for outpatient services.

4.5.1 Once eligibility for Financial Assistance is approved, the write-off amount on each account is 100% and will be credited on the patient account.

4.5.2 The effective date of eligibility is determined by the first qualifying date of service within the last three (3) months or date of service forthcoming.

4.5.2.1 If a patient receives a bill past the 90-day qualifying date, due to a delay in primary insurance paying, the patient may apply for financial assistance up to 30 days after payment is received from insurance.

4.5.3 The eligibility period is on a case-by-case basis and may be valid for six (6) months.

4.6 Applicant should be internally screened and/or denied for Medicaid, and other programs prior to approval for financial assistance. Failure to cooperate with Medicaid and other programs should disqualify the applicant for financial assistance.

4.7 If unemployed and able to work, applicant should register with the Texas Workforce Commission.

4.8 If disabled, applicant must have applied and have confirmation for disability benefits under the Social Security Act.

4.9 If employed, applicant should apply and receive a denial with the Texas Workforce Solutions prior to approval for financial assistance.

4.10 When applicable, Charity will be added as a primary or secondary I-Plan.

5.0 Application

A Financial Assistance Application (**Attachment A**) along with instructions for completion (**Attachment B**) will be provided upon request to patients seeking financial assistance for health care services. Documentation to support proof of residence, proof of income and qualifying members of the household is required.

5.1 Application should be sent to:

Hunt Memorial Hospital District
Financial Assistance
P. O. Drawer 1059
Greenville, TX 75403-1059
fa@huntregional.org

Applicant must complete the Application for Financial Assistance and submit the following

documents:

5.2 Proof of residence

5.2.1 A valid Texas Driver's License or other official photo identification with a current Hunt County address should be provided before processing the application.

5.2.1.1 If a person has no residence of his own and is living in Hunt County, the financial assistance application will be handled on a case by case basis.

5.2.2 To verify Hunt County residency, the applicant should provide one or more of the following:

5.2.2.1 Rent, mortgage payment or utility receipt, current voter registration card, property tax receipt, school enrollment records and/or automobile registration.

5.2.3 A person is not considered a resident of Hunt County if the person attempted to establish residency solely to obtain financial assistance.

5.3 Proof of Income

The income of all household members is considered (see Section 5.4). Applicant must declare all household income and provide documentation in support of all income to include if applicable:

5.3.1 Wages, Salaries, and Commissions
For purposes of this policy, salary income is defined as gross salary less federal income tax, Social Security withholding (FICA) and Medicare withholding, defined as net income.

5.3.1.1 Paycheck stubs with year-to-date earnings for two months prior to date of service to current. (i.e. month of service plus two months prior) **or**

5.3.1.2 Letter from employer on appropriate letterhead or business card verifying wages for two months prior to the date of service to current **and/or**

5.3.1.3 Federal tax return for the most recent filing period, to include supporting documents will be required.

5.3.1.4 Self-employed Applicants:

5.3.1.4.1 Self-employed applicants must also supply a Profit and Loss Statement. If a Profit and Loss Statement is not available, the Statement of Self-Employment Income Form (**Attachment C**) should be completed by the applicant.

5.3.1.4.2 Bank statements should support the Profit and Loss Statement and/or **Attachment C**.

5.3.1.4.3 If they are incorporated, the patient should supply all pages of their individual and business income tax returns. If applicable, all Forms 1099's should be included.

5.3.1.4.4 If they are self-employed and not incorporated, they should supply all pages of their individual income tax return, which should include appropriate Schedules (i.e. Schedule C, Schedule E, Schedule F or any other Schedule).

5.3.1.4.5 The quarterly Estimated Tax Voucher (1040ES) may also serve as supporting documentation.

5.3.1.5 Bank statements (to include all checking and savings accounts) for three months prior to date of service to current should be provided.

5.3.1.5.1 All information on each bank statement and shared account will be considered in order to determine criteria.

5.3.1.5.2 A deposit is considered income unless a receipt or documentation is provided indicating otherwise (i.e. a loan).

5.3.1.6 Social Security income, tip income, income arising from a worker's compensation claim, unemployment income, trust fund income, pensions, VA payments, rental income, child support and other potential payment sources such as third party liability, car insurance, homeowners insurance or commercial liability insurance.

5.3.2 Resources

5.3.2.1 The maximum amount of resources allowed is $2,000 per household in order to qualify.

5.3.2.2 There is a $3,000 total resource limit if there is an aged (65 or older) or disabled person living in the household in order to qualify.

5.3.2.3 Examples include but are not limited to: Bank accounts (checking and savings), cash, bonds, certificates of deposit, gas, oil or mineral rights, notes, stocks, retirement accounts, real properties, including buildings and land other than a homestead, vehicles, boats, campers, recreational vehicles or any other assets determined as an eligible asset.

5.4 Household

For purposes of this policy, a household is a person living alone or two or more persons living together where support exists.

5.5 Changes to Information

HMHD shall explain to the applicant or approved patient, that he or she should report within fourteen (14) days any changes in address, income, household, application or receipt of SSI, CHIP, Medicaid, TANF, or health insurance. Failure to report any such changes may result in losing assistance from HMHD and future disqualification. HMHD shall explain the possible penalties for failure to report such a change.

6.0 <u>Hospital Services</u>

6.1 Hunt County residents eligible for the Financial Assistance Program will be treated at any HMHD entity.

6.1.1 Procedure(s) and/or test(s) must be medically necessary according to the Medicaid Program. Reimbursement for the care of any patient will be based on medical necessity and excludes consideration for elective services, hospital durable medical equipment and supplies. Guidelines followed are specified in the Texas Health and Human Services Commission (HHSC) manual and/or the County Indigent Health Care Program (CIHCP) handbook.

6.1.1.1 Medicaid and Medicaid HMO charges that are *"not a benefit"* or *"non-covered"* will be adjusted off of the patient's claim and deemed charity without any asset or income verification. The patient will not receive a bill.

6.1.2 If medical necessity is in question, a clinical case review may be warranted by either the Chief Medical Officer, Chief of Staff and/or a relevant physician.

6.1.3 The purpose of such review is to determine if the case is medically necessary or considered elective.

6.1.4 Should a clinical case review be warranted, it should not be completed by the ordering physician.

6.1.5 Once medical necessity is established, therapy services may be subject to limited visits, depending on diagnosis, conditions and reassessments, contingent on the evaluating therapists.

6.1.6 Services provided at other healthcare facilities will be considered only if transferred or referred from HMHD. Other services may be considered on a case-by-case basis.

6.1.7 Non HMHD facilities should provide verbal notification within 72 hours and written verification with five (5) days from the date of service to be eligible for payment.

6.2 Payment for services at other facilities will be at HMHD approved rates.

6.2.1 Outpatient facility services will be reimbursed at 75% of the current Medicaid Fee Schedule.

6.2.2 Inpatient services will be reimbursed at 50% of the facilities' APR-DRG Standard Dollar Amount x the APR-DRG Weight. Formula: SDA x APR-DRG WT x 50%.

6.2.2.1 The maximum payout per service to other facilities is $5000.

6.3 Indigent: Inmates - All inmates will be added in the system as indigent, with the exception of juveniles.

6.3.1 Incarcerated juveniles will be considered indigent if there is no insurance available through the guarantor.

6.3.2 Indigent should be added as the secondary I-Plan if there is insurance besides Medicare or Medicaid.

6.3.3 Indigent will be the only I-Plan listed on the account if the patient is Medicare or Medicaid eligible.

7.0 Physician Services

7.1 Hunt County residents eligible for the Financial Assistance Program will be treated by HMHD physicians.

7.1.1 A HMHD physician is any physician that is on staff at our facility.

7.1.2 Hunt Regional Medical Partners physicians and practitioners are excluded from this section.

7.2 Services provided by a non-HMHD physician will be considered only after the individual has been evaluated by a HMHD medical staff member through a HMHD emergency room and/or as an inpatient (not through an office visit).

7.3 Physician services considered "non-covered" under the Medicaid Program are not eligible for reimbursement under the HMHD Financial Assistance Program.

7.3.1 Remaining patient portion amounts due to the physician, after primary insurance payments, are not reimbursable under the Financial Assistance Program. This includes deductibles, co-insurance, and co-pays.

7.4 Eligible physicians/specialists will be reimbursed for professional services performed at a HMHD entity.

7.4.1 Emergency Department – A physician/specialist will be reimbursed for one visit when referred by the Emergency Department.

7.4.1.1 The first visit may be in the Emergency Department as a consultant or in the physician's office within thirty (30) days of the date of service.

7.4.1.2 HMHD may reimburse for eligible presumptive charity applicants who require emergency OB/GYN services and surgical procedures.

7.4.1.2.1. Presumptive charity is defined as a town call patient living within Hunt County with no recorded third party payer (i.e. Governmental or Commercial payers).

7.4.1.2.2 Emergent is defined as patients arriving of their own will through the Emergency Rooms of HMHD.

7.4.2 Inpatient – HMHD will reimburse for one follow-up visit occurring within thirty (30) days of discharge.

7.4.3 Outpatient/Same Day Surgery – HMHD will reimburse for one follow-up visit occurring thirty (30) days from the date of surgery.

7.5 Payment for eligible physicians/specialists will be at 75% of the current Medicaid Fee Schedule. If Medicaid deems CPT code not allowed, then eligibility for payment is denied.

7.6 A physician's claim (HCFA1500) should be received within 95 days of the approval date (the first date the application is approved) or the add date (the date Charity is added to the account as primary) for financial assistance.

7.6.1 If charity is loaded as a secondary payer, physician reimbursement is not eligible.

7.6.2 If a patient is requiring surgery and pending Medicaid SSI eligibility, the surgeon's payment will be considered on a case by case basis.

7.7 If the physician accepts payment from the facility under the HMHD Financial Assistance Program, the physician should not balance bill the patient.

8.0 Funding

8.1 Funding for the Financial Assistance Program is derived from the HMHD Taxing Authority.

8.2 Any deposit made by the patient or guarantor prior to Financial Assistance approval, is non-refundable.

8.3 A maximum annual amount for financial assistance will be determined in the HMHD budget and taxation annual process.

8.4 Amount of financial assistance allocated in the budget is determine by HMHD's charity financial history, and is approved by the HMHD Board of Directors on an annual basis.

9.0 Review and Approval

9.1 Completed applications for eligible Hunt County residents with all required supporting

documentation will be reviewed and processed by the Financial Counselor.

9.2 A Financial Assistance Determination Worksheet will be completed by the Financial Counselor and a determination will be made.

9.3 The Financial Counselor will determine eligibility based on the Federal guidelines and the guidelines outlined in this policy.

9.3.1 The balance will be adjusted on the patient account to reflect a $0 balance.

9.4 HMHD shall provide an applicant written notification of its eligibility decision. If HMHD denies assistance, the written notification shall include the reason for the denial and an explanation of the procedure for appealing the denial.

9.5 An approved application will be valid for six (6) months from the first date of service that the patient is found eligible.

9.5.1 Recurring Accounts (RCR) may be valid through the end of the active month.

9.5.2 Hunt Regional Home Health accounts may be valid through the end of the sixty-day clinical episode.

9.6 A Financial Assistance Eligibility Determination letter, for the qualifying period, will be issued by the Financial Counselor for all approved and denied applicants.

9.7 For quality control, applications for services in excess of $8,000 in charges must be reviewed for approval by an assigned Patient Accounting employee and the PFS Director.

9.7.1 If the Patient Accounting Employee is unavailable, the Patient Accounts Manager may review and approve applications and will then forward them to the PFS Director.

9.7.2 If the PFS Director is unavailable, the Patient Accounting Employee will review the application and then forward it to the Patient Accounts Manager. Once each application is approved or denied, the Manager will forward the application back to the Financial Counselors.

9.7.3 A summary report, listing volume and amounts, will be given to the Chief Financial Officer (CFO) on a monthly basis.

10.0 <u>Right of Appeal</u>

10.1 Every applicant has the right to request an appeal of a denied application within one month from the denial date on the letter.

10.2 The applicant should provide a letter of appeal and any documentation to support their case to overturn and approve the application.

10.3 Financial Counselor will initiate the appropriate appeal data to the PFS Director for review.

10.3.1 PFS Director will initial the Financial Assistance Appeal Form, and schedule an Appeal committee meeting.

10.4 The Financial Assistance Appeal Form, and any supporting documentation will be reviewed by the Appeal Committee which consists of the following:

10.4.1 HMHD Chief Financial Officer
10.4.2 HMHD Patient Financial Services Director
10.4.3 HMHD Medical Staff Director/Member
10.4.4 Other employee's may be invited, as an adhoc member of the Appeal Committee, if warranted (i.e. Social Worker, etc.)

10.5 Should an appeal be overturned by the committee with a stipulation, the applicant will be made aware and the account will be documented.

10.6 Decisions of the committee are final.

11.0 Record Retention

HMHD shall maintain all records relating to an application for at least three (3) years after the date on which an application is submitted in accordance with the HMHD's policies on business records retention as well as federal and state laws governing records retention.

12.0 Attachments

12.1 A – Financial Assistance Application

12.2 B – Financial Assistance Program Letter

12.3 C – Statement of Self-Employment Income Form

12.4 D – Federal Poverty Guidelines

12.4.1 Revised Annually

Hunt Regional Healthcare

ATTACHMENT A
For Patient to Complete

Hunt Memorial Hospital District
Financial Assistance Application

Patient Information:

Name: (Last) ______________________, (First) ______________________ (Middle) ____________

Physical Address: ______________________ Social Security #:______-______-______

(City, State, Zip) ______________________ Date of Birth: _____/_____/_______

Mailing Address: ______________________ Marital Status: Married / Single / Divorced / Widowed / Separated

(City, State, Zip) ______________________ Home Phone (_____) ______-__________

Email Address:______________________ Cell/Other (_____) ______-__________

☐ Employed Status: ____ FT _____ PT _____TEMP Date of Hire:______________________

☐ Unemployed Last Day Worked:______________________ How Long Employed:______________________

Employer: ______________________ Employer Phone # (_____) ______-______

Address: ____
(Street) (City) (State) (Zip)

Health Insurance? Yes or No Insurance Carrier:______________________

Spouse or Person Who Provides Support:

Name: ______________________Social Security #:______-______-______

Address: ______________________ Date of Birth: _____/_____/_______

(City, State, Zip):______________________ Phone (_____) ______-__________

☐ Employed Status: ____ FT _____ PT _____TEMP Date of Hire:______________________

☐ Unemployed Last Day Worked:______________________ How Long Employed:______________________

Employer: ______________________ Employer Phone # (_____) ______-______

Address: ____
(Street) (City) (State) (Zip)

Section A. Wages: Please provide the wages for each of the following persons in your household – patient, spouse and/or others who provide support.

Patient $______________ Hr / Wk / Month / Year Spouse $______________ Hr / Wk / Month / Year

Other $______________ Hr / Wk / Month / Year Other $______________ Hr / Wk / Month / Year

Section B. Resources: Please provide the total amount of other resources available to you, including savings accounts, checking accounts, stocks, bonds, trust funds, etc. $______________

Please provide the amount of monthly / yearly income you receive from these other resources, including interest income, dividends, rental income, etc. $______________

Section C. Household Members: Please provide the number of persons in the patient's household: ________

Section D. Income and Household Verification: Please provide the following documents to verify household income:

* Paycheck Stubs or Employer Verification
* Tax Return
* Bank Statements
* Social Security
* Unemployment Compensation
* Worker's Compensation
* Savings Account(s)
* Food Stamps
* Other (ie: Self-employed)
* VA Payments
* Governmental Assistance
* Child Support

For Other, please describe:

____

____

I understand that HMHD may verify the information contained in this Financial Assistance Application in connection with the evaluation of this application, and by my signature, I hereby authorize my employer to certify the information provided in this application. I agree to report any of the following changes within 14 days: income, resources, the number of people who live with me, address, and application for, or receipt of, SSI, TANF or Medicaid. Failure to report any changes may result in loss of eligibility and disqualification from future participation.

Falsification of information may result in denial of the Financial Assistance Application. If, after a patient is granted financial assistance, HMHD finds material provision(s) of the application to be untrue, Financial Assistance status may be revoked.

______________________________ ______________________
Signature of Patient or Responsible Party Date

______________________________ ______________________
Hospital Approval/ Title Date

For Hospital Use Only:

MR#:________________ **Acct #:**________________ **DOS:**________________

Inpatient ____________ Outpatient ____________ ER ____________

Reason for visit
(Diagnosis):____

ATTACHMENT B
Patient Information Only

Hunt Memorial Hospital District
Financial Assistance Program Letter

Dear Patient:

As part of our commitment to serve the community, Hunt Memorial Hospital District elects to provide financial assistance to meet the medical needs of uninsured and under-insured residents of Hunt County.

To determine if a person may qualify for financial assistance, we need to obtain certain financial information as outlined within this application. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Eligibility for financial assistance is determined, in part, by comparing a family's income to the Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services. We will also use other resources and assets to determine eligibility for the program.

Please complete the Financial Assistance Application and return the completed form, with all necessary documents, to the **Financial Assistance Office** or by mail to the following address:

Hunt Memorial Hospital District
Financial Assistance
P. O. Drawer 1059
Greenville, TX 75403-1059
fa@huntregional.org

You will continue to receive statements and attempts to collect this debt until such time that the application is approved for assistance.

Please find the instructions for completing the Financial Assistance Application on the back. Should you need assistance in completing the form, feel free to contact us at **903-408-1121, Monday through Friday between the hours of 8:00a.m. - 4:30p.m.**

Any consideration or potential approval of assistance applies to services provided by Hunt Memorial Hospital District. The following requirements should be met in order for the application to be accepted:

- Applicant must reside in Hunt County on or before the date of service.
- A valid Texas Driver's License or other official photo identification with a current Hunt County address should be provided before processing the application.
- Applicant must be a U.S. Citizen or in the U.S. legally.
- Applicant must have a current account for services provided within the past three (3) months at HMHD or have a current physician's order for outpatient services. Once eligibility for Financial Assistance is approved, the write-off amount on each account is 100% and will be credited on the patient account.
- Applicant will be internally screened and denied for Medicaid, and/or other programs prior to approval for Financial Assistance. Failure to cooperate with Medicaid, and/or any other programs will disqualify the applicant for Financial Assistance.
- If unemployed and able to work, applicant should register with the Texas Workforce Commission.
- If disabled, applicant must have applied and have confirmation for disability benefits under the Social Security Act.
- If employed, applicant should apply and receive a denial with the Texas Workforce Solutions prior to approval for financial assistance.

INSTRUCTIONS for Completing the Financial Assistance Application

Please complete the **Patient/Spouse** information and then proceed to the following sections:

Section A: Wages

In Section A of the Financial Assistance Application, please indicate and provide proof for the Dollar Amount each listed person receives as compensation and whether the amount represents hourly, weekly, or yearly compensation. A household consists of a person living alone or two or more persons living together where support exists.

Section B: Resources

In the first blank in Section B of the Financial Assistance Application, please indicate and provide proof for the Dollar Amount that you have invested in bank accounts (checking and savings), cash, bonds, certificates of deposit, gas, oil or mineral rights, notes, stocks, retirement accounts, real properties, including buildings and land other than a homestead, vehicles, boats, campers, recreational vehicles or any other assets determined as an eligible asset.

In the second blank please indicate and provide proof for the Dollar Amount of income, investments or other funds you receive on a monthly/ yearly basis. For example, in the first blank one might put that they have $5,000 in a savings account and in the second blank they might put that they earn $250 interest yearly on that account.

Section C: Household Members

Section C of the Financial Assistance Application requests information on the number of persons in the patient's household. This number should include the patient, spouse, dependents and **any** other person living in the household providing support. If the patient is a minor, please include the patient, the patient's mother/father/legal guardian and any resident dependents.

Section D: Income and Household Verification

In order to consider your request for financial assistance, verification of the wages reported in Section A of the Financial Assistance Application is required.

For verification of your household income and resources, the following documents need to be provided (three months prior to the date of service to current): Paycheck Stubs or Employer Verification, Tax Return (required for self-employed), Bank Statements, Savings Account(s), Child Support, Worker's Compensation, Social Security, Unemployment Compensation, VA Payments, Governmental Assistance, Food Stamps and any other household income.
Also provide a copy of a current Utility bill and/or Property Tax statement.

- *Note: If you are unable to provide one of the sources of income documentation listed above, please provide a written explanation in Section D of the Financial Assistance Application.*

TEXAS Health and Human Services

Form H1049
December 2015-E

Facts About Self-Employment Income

ATTACHMENT C
For Patient to Complete

Self-employment income is any money you make working for yourself or as a subcontractor. If you have an employer who pays you and takes out taxes, you're not self-employed.

You might be self-employed if you are a: babysitter, landscaper, day laborer, house cleaner, hair stylist, auto mechanic, or person who makes money from sales, crops, leases, commissions, fees, or anything you do or sell.

If anyone on your benefits case gets money from self-employment, you need to: (1) fill out this form and return it to us and (2) send proof of the facts you give on this form: receipts, invoices, or other papers (all original items sent with this form will be returned to you).

You also can send proof of the facts you give on this form by uploading your papers and forms on the **Your Texas Benefits Mobile App**, or our website, **YourTexasBenefits.com**.

If you use this form to show your self-employment income:

- Answer all questions and sign and date at the bottom. This is your sworn statement of income.
- You can ask another person to help you fill out this form, but that person also must sign this form.
- Use more sheets of paper if you need to. You must sign and date each sheet.

---

1. Name (person getting money from self-employment): ______________________
2. What type of work do you do to earn this money? ______________________
3. How many hours do you work each week? ______________________
4. Fill out the table below to tell us how much money you get from self-employment.
   - Tell us about money from self-employment from the past 2 months. If you don't get paid every month, tell us about your most recent payments.
   - List the date you were paid, who paid the money, and the amount paid.
   - Add the income amounts and enter the total in the box "Total self-employment income."

How to fill out the table:

Date	Who paid this money	Amount paid
		$
		$
		$
		$
		$
		$
		$
		$
		$
	Total self-employment income:	$

5. Fill out the table below to tell us how much it costs for you to work (self-employment expenses).

Expenses can include:

- Advertising (signs, flyers).
- Business property.
- Business rent and utilities.
- Costs of labor (list each person and the amount you paid them).
- Equipment.
- Interest paid on business loans.
- Materials used to make a product.
- Operating supplies.
- Professional fees, legal fees, licenses and permits.
- Repairs to business equipment or vehicles.

Expenses can't include:

- Rent, taxes, utilities, or interest on mortgage for your business if it operates out of your home (unless these costs are separate from the costs of your home).
- The cost of goods you buy for the business, but use yourself.

How to fill out the table:

- Tell us about expenses from the past 2 months.
- If you don't pay an expense every month, tell us about your most recent expenses.
- List the date of the expense, the type of expense, and the amount of the expense.
- Add the expenses and enter the total in the box "Total self-employment expenses."

Date	Type of expense	Amount paid
		$
		$
		$
		$
		$
		$
		$
		$
		$
	Total self-employment expenses:	$

Reminder ► Send proof of the facts you gave on this form: receipts, invoices, or other papers.

Who must sign ► The form must be signed by the person getting self-employment income or their spouse or authorized representative. Anyone can help you fill out the form, but that person also must sign this form.

By signing below, I agree that: The answers on this form are true and complete to the best of my knowledge.

If they aren't, I know I might: (1) be charged with a crime, and (2) have to repay benefits.

Signature of person getting self-employment income **Date**

Signature of anyone helping you fill out this form **Date**

In most cases, you can see and get facts HHSC has about you. This includes facts you give HHSC and facts HHSC gets from other sources (medical records, employment records, etc.). You might have to pay to get a copy of these facts. You can ask HHSC to fix anything that is wrong. You do not have to pay to fix a mistake. To ask for a copy or fix a mistake, call 2-1-1 or 877-541-7905 (after you pick a language, press 2).

For Agency Use Only	
Case No.	Case Name

TEXAS
Health and Human Services

Form H1049-3
December-2015-E

Self-Employment Income Worksheet

(For Department Use Only)

Name of Self-Employed Person

I. Computation of Monthly Self-Employment Income (Annual or Seasonal)

A. Gross income from self-employment *(including capital gains)* .... $

B. Total allowable business expenses .... $

C. Net monthly self-employment income *(Line A less Line B)* .... $

D. Number of months covered by income statement .... $

E. Monthly self-employment income *(divide Line C by Line D)* .... $

II. Computation of Monthly Self-Employment Income

III. Computation of Farm Loss

A. Total monthly self-employment income (non-farm) *(Add all self-employment income from Form H1049, Step I, Line E.)*

$

B. Monthly farm loss amount

$

C. If Line A is more than Line B, subtract B from A. This is the amount of self-employment income to enter on Form H1801, Step 2.1, and to include on Form H1101, Page 3, Step 1, Line 2; Form H1102, Page 2, Step 1, Line 2; and Form H1119, Step 1, Line 2.

$

D. If Line B is more than Line A, subtract A from B. This is the amount of remaining farm loss to enter on Form H1801, Step 3.3; Form H1101, Page 3, Step 4, Line 10; Form H1102, Page 2, Step 4, Line 10; and Form H1119, Step 2, Line 4. *(Self-employment income is $0.)*

$

IV. Documentation

Signature – Texas Works Advisor **Date**

ATTACHMENT D
Patient Information Only

2022 FEDERAL POVERTY GUIDELINES		
ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.		
MONTHLY GUIDELINES		
FAMILY	PERCENT OF POVERTY	
SIZE		200%
1		$2,265.00
2		$3,052.00
3		$3,838.00
4		$4,625.00
5		$5,412.00
6		$6,198.00
7		$6,985.00
8		$7,772.00
For more than 8 family members, add:		$787.00

Reference: https://aspe.hhs.gov/poverty-guidelines
Produced by: Department of Health and Human Services (HHS)

Hunt Regional Healthcare

ATTACHMENT D (2023)
Patient
Information Only

2023 FEDERAL POVERTY GUIDELINES

All States (Except Alaska and Hawaii) and District of Columbia

Monthly Guidelines

FAMILY SIZE		PERCENT OF PROVERTY 200%
1		$2,430
2		$3,287
3		$4,143
4		$5,000
5		$5,857
6		$6,713
7		$7,570
8		$8,427
FOR MORE THAN 8 FAMILY MEMBERS, ADD FOR EACH PERSON:		$857

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

Produced by: Department of Health and Human Services (HHS)

Revised 01.17.2023 J. Smith