



# Hidalgo County Health & Human Services Department

## Charity Care Program

### Financial Assistance Policy

Effective October 1, 2025

#### I. Introduction

The Charity Care Program Financial Assistance Policy applies to all Hidalgo County Health & Human Services Department clinics and programs (referred to herein as “HCHHSD”) that provide public healthcare services and other prevention and self-management programs. HCHHSD is authorized to charge fees in accordance with the Texas Health and Safety Code, Section 121.006, and the HCHHSD Self Pay Client’s Fee Schedule approved by the Hidalgo County Commissioners Court.

#### II. Purpose

HCHHSD is committed to providing high-quality public healthcare services to prevent disease, improve health status, prolong life, and promote conditions conducive to healthy lifestyle to all Hidalgo County Residents. HCHHSD aims to ensure that an individual’s financial situation does not prevent them from seeking or receiving care.

In accordance with the Texas Health and Safety Code, Section 121.006, and in accordance with the approved Fee Schedule HCHHSD may charge fees for public health services; however, no one will be denied services due to an inability to pay. HCHHSD provides financial assistance for individuals who cannot afford to pay in full or in part.

All services are provided without discrimination and regardless of a person’s financial situation.

#### III. Policy

All patients and clients receiving public health services, including those who are low-income, uninsured, or underinsured, will be treated fairly and with respect before, during, and after receiving services, regardless of their ability to pay.

The granting of Financial assistance shall be based on an individual’s determination of financial need, consistent with Hidalgo County’s nondiscrimination policy, and shall not consider, race, religion, national origin, sex, sexual orientation, gender identity, veteran status, age, or disability, unless exempt by State or Federal law.

a. Eligibility Criteria

In cases where patients are covered by Medicaid or private insurance, HCHHSD will bill Medicaid or the individual's private insurance company for clinic program fees at the applicable Medicaid or private insurance company's reimbursement rate.

Patients not covered by Medicaid, private insurance, or enrollment in a qualified immunization program may be assessed fees based on the approved HCHHSD Self Pay Client's Fee Schedule. No patient otherwise qualified to receive public health clinic services will be denied said services based on an ability to pay the approved fees.

HCHHSD does not collect on past due accounts. Once a patient is determined to be eligible for financial assistance, that patient shall not receive any future bills based on undiscounted gross charges.

b. Eligibility Determination

HCHHSD personnel may ask patient(s) to provide information regarding employment status, insurance status, governmental program assistance status, household members, household income, and residence at the time of service.

A patient who requests a discounted payment, charity care, or other assistance from HCHHSD, may be asked to provide income and health benefits coverage documentation.

Patients indicating their inability to pay will not be denied services and will be eligible for partial or full free reductions. of fees in whole or in part.

Patients will be asked to fill out an inability to afford payment of healthcare costs **Form HCHHSD B03-1**. If patient is unable or unwilling to sign **Form HCHHSD B03-1**, an HCHHSD employee will witness and sign the form.

c. Community Notification

Information about HCHHSD Charity Care Program Financial Assistance Policy will be publicly available through posted notices in registration areas, public health clinics, public health laboratories and on the HCHHSD [website](#).

Notice will also be provided to potentially eligible patients at the date of service, or as soon as possible thereafter, and during the payment collection process.

This information will be provided in English and Spanish and may be translated for patients in other languages as necessary, including American Sign Language.

d. Regulatory Requirements

This policy was developed with consideration of applicable local, state, and federal regulations.

#### IV. Definitions

For the purpose of this policy, the terms are defined as follows:

- a. **Charity Care Program:** Hidalgo County HHS may provide charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for government programs, or otherwise unable to pay, for medically necessary, preventative care (as defined by Tex. Admin. Code § 355.8215) based on their individual financial situation.
- b. **Emergency Medical Conditions:** A condition with acute symptoms of such severity that the absence of immediate medical attention could result in serious harm, such as a life-threatening situation, serious impairment of bodily functions, or serious dysfunction of a body part. (Emergency Medical Treatment and Labor Act)
- c. **Family/Household:** 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.
- d. **Financial Assistance:** A provider's policy to provide services at a partial or full reduction. to individuals who meet the established criteria without expectation for standard payment.
- e. **Household Income:** Total gross income of all household members, including wages, salaries, government benefits, and other sources of support.
- f. **Gross Charges:** The total charges at the organization's approved Self Pay Client's Fee Schedule for the provision of patient care services before deductions from revenue applied.
- g. **Inability to pay:** Patient lacks the funds to meet the financial obligation of public health care services.
- h. **Self-management programs:** Structured interventions designed to help individuals manage chronic conditions or health-related behaviors on their own with the support of education, skill-building, behavioral change, and empowerment.
- i. **Underinsured:** The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed their financial abilities.
- j. **Uninsured:** The patient has no level of insurance or third-party assistance to assist with meeting his/her payment obligations.

**V. Policy Authority**

For claims, appeals, interpretations, resolution of problems, and special situations contact:

Hidalgo Count Health & Human Services  
Finance Department  
1304 South 25<sup>th</sup> Avenue  
Edinburg, Texas 78542

Telephone (956) 383-6221  
Facsimile (956) 318-2421  
Monday through Friday 8:00 AM to 5:00 PM (Central Time)

**Attachment 1 – List of Participating Providers**

This policy is inclusive of all public health services at HCHHSD, which operate under the medical authority of the Local Health Authority and Lab Medical Director of Hidalgo County at the listed locations:

Facility	City, State	Phone Number
Edinburg Public Health Clinic	Edinburg, Texas	956-318-2040
Elsa Public Health Clinic	Elsa, Texas	956-262-1141
Alton "El Paraiso" Public Health Clinic	Alton, Texas	956-383-6221
Weslaco Public Health Clinic	Weslaco, Texas	956-968-8541
Pharr Public Health Clinic	Pharr, Texas	956-787-3980
Mission "La Mansion" Public Health Clinic	Mission, Texas	956-581-8596
Hidalgo Public Health Clinic	Hidalgo, Texas	956-843-7463
Pulmonary Public Health Clinic	Edinburg, Texas	956-387-0118
McAllen Public Health Clinic	McAllen, Texas	956-682-6155
Public Health Laboratory	Edinburg, Texas	956-292-7765
John Austin Pena Memorial Center	Edinburg, Texas	956-318-2915

HCHHSD Website:

<https://tx-hidalgoahhs.civicplus.com/>

Attachment 2 – HCHHSD B03-1 Form



Dairen Sarmiento Rangel, M.B.A. | Director  
 1304 S. 25<sup>th</sup> Ave., Edinburg, TX 78542 · Tel: (956) 383-6221 · Fax: (956) 383-8864 · www.hchd.org

## Statement of Inability to Afford Payment of Healthcare Costs

Date: \_\_\_\_\_ Client ID #: \_\_\_\_\_  
 Client Name: \_\_\_\_\_ Payor Name: \_\_\_\_\_

I certify that I am unable to pay the total of \$ \_\_\_\_\_, and can partially pay \$ \_\_\_\_\_ for the services provided to me today.

X \_\_\_\_\_  
 (Signature of Client / Payor) (Date)

Client refused to sign

Staff Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Print Name Signature

Approved by RN / LVN: \_\_\_\_\_ Date: \_\_\_\_\_  
 Print Name Signature

**For Billing Office Use Only**

<u>Amount</u>	<u>Procedure Code</u>	<u>Amount</u>	<u>Procedure Code</u>
\$ _____	_____	\$ _____	_____
\$ _____	_____	\$ _____	_____
\$ _____	_____	\$ _____	_____

Total of Fees \$ \_\_\_\_\_ Total Collected \$ \_\_\_\_\_ Uncollected Amount \$ \_\_\_\_\_

Staff Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Print Name Signature

Approved By: \_\_\_\_\_ Date: \_\_\_\_\_  
 Print Name Signature