Uncompensated Trauma Care Application Summary CY 2022

1) The data is requested from DSHS.
2) Patient population are trauma patients that meet registry criteria.
    a. Transfer
    b. Expired
    c. From ER to OR
    d. Admitted for longer than 24 hours.
3) Uncompensated trauma care-The sum of "bad debt" and "charity care" resulting from trauma care after due diligence to collect. Contractual adjustments in reimbursement for trauma services based upon an agreement with a payor are not uncompensated care.
4) In CY2022 there were 102 patients that met Registry Criteria
5) Out of the 102 patients 30 of these patients met the UCC criteria.
6) Total Uncompensated Charges for CY2022 was $261,230.44

Department of State Health Services (DSHS)
EMS/Trauma Systems (EMS/TS)
Uncompensated Trauma Care Application
Calendar Year 2022

Due May 1, 2024

PART B – AFFIDAVIT
(NOTE: This form must be completed **with required signatures individually notarized** to be eligible for funding).

Hospital Name: Moore County Hospital District DBA Memorial Hospital

I, Jeff Turner, **Chief Executive Officer/Trauma Hospital Administrator** for the hospital named above, swear, or affirm that the information contained in this application is true and correct. I also swear or affirm that I have fully read and understand the stipulations listed in this application.

Notary Information (REQUIRED):

Subscribed and sworn before me, a Notary Public, on _____ (date).

_____ _____

Notary Public (Print) Notary Public (Signature)

County: _____ My Commission expires: _____

State of: _____ **Notary Stamp Here**:

Chief Executive Officer:

_____ _____

Name (print) Signature

Department of State Health Services (DSHS)
EMS/Trauma Systems (EMS/TS)
Uncompensated Trauma Care Application
Calendar Year 2022

Due May 1, 2024

PART B – AFFIDAVIT
(NOTE: This form must be completed **with required signatures individually notarized** to be eligible for funding).

Hospital Name: Moore County Hospital District DBA Memorial Hospital

I, John Frantz, **Chairman of the Board of Directors** for the hospital named above, swear, or affirm that the information contained in this application is true and correct. I also swear or affirm that I have fully read and understand the stipulations listed in this application.

Notary Information (REQUIRED):

Subscribed and sworn before me, a Notary Public, on _____ (date).

_____ _____

Notary Public (Print) Notary Public (Signature)

County: _____ My Commission expires: _____

State of: _____ **Notary Stamp Here:**

Chairman of the Board of Directors:

_____ _____

Name (print) Signature

Department of State Health Services (DSHS)
EMS/Trauma Systems (EMS/TS)
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Due May 1, 2024

PART B – AFFIDAVIT
(NOTE: This form must be completed **with required signatures individually notarized** to be eligible for funding).

Hospital Name: Moore County Hospital District DBA Memorial Hospital

I, John Sharp, **Chief Financial Officer** for the hospital named above, swear, or affirm that the information contained in this application is true and correct. I also swear or affirm that I have fully read and understand the stipulations listed in this application.

Notary Information (REQUIRED):

Subscribed and sworn before me, a Notary Public, on _____ (date).

_____ _____

Notary Public (Print) Notary Public (Signature)

County: _____ My Commission expires: _____

State of: _____ **Notary Stamp Here**:

Chief Financial Officer:

_____ _____

Name (print) Signature

Department of State Health Services (DSHS)
EMS/Trauma Systems (EMS/TS)
Uncompensated Trauma Care Application
Calendar Year 2022

Due May 1, 2024

PART B – AFFIDAVIT
(NOTE: This form must be completed **with required signatures individually notarized** to be eligible for funding).

Hospital Name: Moore County Hospital District DBA Memorial Hospital

I, Yessenia Longoria, **Chief Nursing Officer** for the hospital named above, swear, or affirm that the information contained in this application is true and correct. I also swear or affirm that I have fully read and understand the stipulations listed in this application.

Notary Information (REQUIRED):

Subscribed and sworn before me, a Notary Public, on _____ (date).

_____ _____

Notary Public (Print) Notary Public (Signature)

County: _____ My Commission expires: _____

State of: _____ **Notary Stamp Here**:

Chief Nursing Officer:

_____ _____

Name (print) Signature