Re: FY 04-05 CHIP Hospital Program Enrollment Form

Dear

The City and County of San Francisco is pleased to enclose the FY 04-05 CHIP Hospital Program Enrollment Form for your review and signature. We have also included a hospital RCC calculation form. In order for your hospital to receive CHIP Hospital Program funds (from State Tobacco Tax revenues), you must submit the following:

1) one original of the “FY 04-05 CHIP Hospital Program Enrollment Form” signed by a duly-authorized representative of your hospital. The administrative contact should be the person who has overall responsibility for use of CHIP Hospital funds. The billing office contact should be the hospital employee responsible for submitting claims to the fiscal intermediary.

2) a completed original of “Calculation of Hospital RCC Form”.

3) a copy of your hospital's written charity care guidelines (as made available to OSHPD).

Please return the above documents by December 8, 2004, addressed as follows:

Jeffrey Leong, AB 75 Coordinator
San Francisco Department of Public Health
1380 Howard Street, 2nd Floor
San Francisco, CA 94103

An executed copy of the enrollment form shall be sent to the hospital’s administrative contact. Lastly, the County Letter outlining policies and procedures for the FY 04-05 CHIP Hospital program, and including a schedule for claims submission and the allocation table, will be sent out soon.

I look forward to our continued partnership in providing hospital services for the medically indigent of San Francisco. If you have any questions, please do not hesitate to call me at: (415) 255-3692.

Sincerely,

Jeffrey Leong
AB 75 Coordinator
Hospital Name ________________________________________________________________

Federal Tax Identification Number ________________________________________________

Administrative Contact _________________________________________________________
Title _______________________________________________________________________
Address _____________________________________________________________________
Phone Number ___________________________  FAX Number ___________________________

Billing Office Contact _________________________________________________________
Title _______________________________________________________________________
Mailing Address _______________________________________________________________
Phone Number ___________________________  FAX Number ___________________________

Send Checks To __________________________________________________________________
Mailing Address _______________________________________________________________
Phone Number ___________________________  FAX Number ___________________________

Ratio of Costs to Charges from Attachment 6 _______________________________________

Hospital Fiscal Year Ends On ___________________________________________________

Assurances

The Hospital agrees to participate in the California Healthcare for Indigents Program (CHIP) as described in Chapter 5, Part 4.7 of the California Welfare & Institutions Code (Section 16900 et.seq.), and San Francisco Administrative Code Section 10.117-98. The Hospital agrees to do the following:

a) Maintain the same number and classification of emergency room permits and trauma care designations as existed on January 1, 1990;
b) Provide data and reports on the use and expenditures of all funds received in a form and according to procedures specified by the San Francisco Department of Public Health and the State Department of Health Services; and

c) Assure that funds received pursuant to the CHIP Program are used only for services for persons who cannot afford to pay for those services and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government.

Hospital agrees to comply with the San Francisco CHIP Hospital Program Conditions of Participation, a copy of which has been provided to the Hospital. Enrollment in the CHIP Hospital Program and compliance with the provisions of the Tobacco Tax and Health Protection Act of 1988 and implementing statutes, San Francisco Administrative Code Section 10.117-98, the CHIP Hospital Program Conditions of Participation, including Attachments 1-9, and any amendments hereafter made to these laws or to the Conditions, qualify the Hospital to receive funds pursuant to those laws and program policies and procedures.

Hospital agrees to comply with County Letter 94-6 and assures that funds paid prospectively to Hospital during the year will be used for indigent health services only, claims will be submitted documenting the use of such funds, and any unused or undocumented balance will be refunded to the CHIP Program.

Hospital agrees to comply with the provisions of the Health Information Portability and Accountability Act (HIPAA) of 1996, the regulations promulgated thereunder by the U.S. Department of Health and Human Services and other applicable laws. Hospital assures that it shall protect the privacy and provide for the security of protected health information by using and disclosing such information in a manner wholly consistent with the privacy requirements of HIPAA.

Signatures

Hospital

City and County of San Francisco

Name ____________________________
Title ____________________________
Signature _________________________
Date _____________________________

Name ____________________________
Title ____________________________
Signature _________________________
Date _____________________________
CHIP HOSPITAL PROGRAM

CALCULATION OF HOSPITAL RATIO OF COSTS TO CHARGES (RCC)

By October 1 of each fiscal year, Hospital shall submit a statement of its Ratio of Costs to Charges (RCC) using the most recently submitted Medicare cost report information, as filed.

The following information must be provided for the calculation of the RCC. Worksheet references are to the Medicare Cost Report.

Total Patient Revenues
   Worksheet G-3, Line 1

Total Costs
   Worksheet A, Column 3, Line 101

Cost to Charge Ratio
   Total Costs divided by Total Patient Revenues