COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES

NON-COUNTY HOSPITALS

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE) (U-1) AGREEMENT FORM

GENERAL INFORMATION

Hospitals must submit a copy of the completed and signed **Trauma Service County Eligibility (TSCE) (U-1) Agreement Form** for each eligible patient's care. if they are claiming reimbursement for Trauma Hospital funds.

Attachment "U-1", shall be utilized by Contractor as the sole means for determining each patient's eligibility for trauma care coverage during the term of this Agreement. The TSCE (U-1) Agreement Form must be completed and signed by the patient or the patient's responsible relative(s).

NOTE: If a TSCE (U-1) Agreement Form cannot be secured because the patient or the patient's responsible relative (s) is (are) unable to cooperate to that effect Attachment "U-2", Hospital Certification of Inability to Cooperate Form must be completed.

Patients unwilling or refusing to cooperate DO NO qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION: Hospitals are required to make reasonable efforts to collect all data elements on the following questions:

- 3rd party coverage question
- Family size/income
- Signature (by patient or responsible relative only)
- Obtain signature of Hospital Reviewer/Translator who obtained information and explained program to patient at the time it is determined that eligibility requirements have been met.

INSTRUCTIONS FOR COMPLETION OF THE TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE) (U-1) AGREEMENT FORM

1. TRAUMA SERVICE HOSPITAL/PHYSICIAN

Enter Trauma Hospital where services where provided

MEDICAL RECORD NUMBER

2. Enter Medical Record Number

3. **DATES OF SERVICE**

Enter month, day, and year of service

4-6 **PATIENT INFORMATION**

Enter patient's last name Enter first name Enter middle initial

7-10 **PATIENT'S ADDRESS**

Enter patient's street address Enter city Enter state Enter zip code

11. SOCIAL SECURITY

Enter patient's social security number

12. TELEPHONE NUMBER

Enter patient's area code and telephone number

13. **BIRTHDATE**

Enter patient's date of birth

14-15 PATIENT'S RESPONSIBLE RELATIVE(S) NAME

Enter name of patient's Responsible Relative (s) (only If patient is unable to sign) Enter full address of Responsible Relative(s)

Key Points Responsible relative means any relative of the patient that can:

 Obtain all information needed to complete the TSCE Agreement, including information regarding the patient's income, family size, and the patient's third-party coverage (if any)

16. **TPL QUESTION**

Check appropriate box to indicate if patient has third party coverage

Key Points

Ensure that the Yes or No box is checked

CIRCLE ONE IN EACH COLUMN BELOW

17. **FAMILY SIZE**

Circle the number of individuals related by birth, marriage, or adoption who usually share the same place of residence

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CIRCLE ONE IN EACH COLUMN BELOW

18. **MONTHLY INCOME**

Circle the appropriate total of patient's or patient's family's primary wage earner's wages and salaries

Key Points

• Write in the patient's monthly income if the total is less than what is indicated on the form

19. YEARLY INCOME

Circle the appropriate total of patient's or patient's family's primary wage earner yearly Income

Key Points

• Write in the patient's yearly income if the total is less than what is indicated on the form

20-21 PATIENT'S SIGNATURE AND DATE

Signature of patient

Enter date

Key Points

• Ensure that patient completes, signs and dates the form at the time it is determined that eligibility requirements have been met.

Note: The patient's Responsible Relative should not sign in this section

22-24 RESPONSIBLE RELATIVE SIGNATURE AND DATE

Signature of the patient's Responsible Relative (only if patient is unable to sign) Enter the relationship to patient

Enter date

Key Points

- Ensure that the patient's Responsible Relative completes, signs and dates the form at the time it is determined that eligibility requirements have been met.
- Include the relationship of the Responsible Relative to the patient

25-26 TSCE HOSPITAL REVIEWER SIGNATURE AND DATE

Hospital Reviewer's Signature

Signature of translator who obtained information and explained program to patient Enter date

Key Points

• Ensure that the Hospital Reviewer signs and dates the form at the time it is determined that eligibility requirements have been met.

This form or a Hospital Certification of Inability to Cooperate (U-2) Agreement Form must be on file in the patient's financial chart

Attachment 6 – Trauma Service County Eligibility (TSCE)

TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE) AGREEMENT

NOTE: Patients unwilling or refusing to cooperate DO NOT qualify for the Trauma Services for Indigents Program. PATIENT INFORMATION: 4 Last 5 First 6 Middle 7 Street 8 City 9 State 10 Zip 11 Social Security Number 12 Telephone Number 13 Birth Date 14 Fatient's Responsible Relative(s) Name(s) 15 Addresses(s) Does patient have third party coverage (i.e., private insurance) which may partially or fully cover the cost of health services on the above date(s) 16 YES (IF YES, PATIENT IS NOT ELIGIBLE) NO TSCE ELIGIBILITY COMPUTATION: (Taken from 2024 Federal Poverty Level 4/1/24) CIRCLE ONE IN EACH COLUMN BELOW: Figure Family Size based on the number of persons in the patient's household. Figure the income of the patient and the patient's responsible relative(s) before taxes and deductions. 17 Family Size 18 Monthly Locome 2	Trauma Service Hospital/Physician 2 Medical Record Number			3 Date(s) of Service		
## Action	NOTE: Patients unwilling or refusing	to cooperate DO NOT qualify for the	Trauma Services	for Indi	gents Program.	
The Street () State () State () To zip () The State () To zip						
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22 Responsible Relative(s) Signature If patient unable to sign	INFORMATION I/WE HAVE GIVEN TO SERVICES ON THE ABOVE DATE(S) I: CERTIFY THAT I/WE HAVE DISCLOSE SERVICES RECEIVED. I/WE UNDERS COUNTY EMERGENCY MEDICAL SER CHARGES INCURRED DURING THE A	DETERMINE MY/OUR TRAUMA SER S TRUE AND COMPLETE TO THE BE D ALL MY/OUR THIRD-PARTY COVE STAND THAT IF I/WE HAVE A THIRD O RVICES, SHALL HAVE THE RIGHT TO ABOVE REFERENCED DATE OF SER	VICE COUNTY EL ST OF MY/OUR K RAGE WHICH MA OR FIRST PARTY RECOVER ALL R VICE AND OTHER	IGIBILITY NOWLED NY PAY F CLAIM O REASONA MEDICA	/ AS CIRCLED ABÓVE FOR HEALTI DGE AND BELIEF. I/WE ALSO OR ANY OF THE COST OF HEALTH DR LAWSUIT, LOS ANGELES ABLE HOSPITAL AND PHYSICIAN	
22 Responsible Relative(s) Signature If patient unable to sign	20. Dationtic County			//	/	
If patient unable to sign	20 Patient's Signature			'Z [Jate ,	
If patient unable to sign	22 Responsible Relative(s) Signature	23 (State relationship to nation!)		2/ 5)	
		20 (Glate relationship to patient)		24 L	Jaic	
	05			/		

THIS FORM OR A U-2 MUST BE ON FILE IN THE PATIENT(S) FINANCIAL CHART Trauma Center Provisions for Reimbursement MOA-Exhibit A

TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE) (U-1) AGREEMENT

Trauma Service Hospital/Physician	Medical Reco	rd Number	Date(s) of S	Service
NOTE: Patients unwilling or re	efusing to cooperate DO NOT qu	ualify for the Trauma	Services for Indiç	gents Program.
PATIENT INFORMATION:				
Last	First	Middle		
Last	Filst	ivildale		
Street	City	State		Zip
	() -		1	1
Social Security Number	Telephone Num	ber	Birth	Date
Patient's Responsible Relative(s)	Name(s)	Addres	epe(e)	
Does patient have third party coverage (i.e			. ,	vices on
the above date(s)?		- and any or rainy obvior and	, coot or moditin our	VI000 011
YES (IF YES, PA	ATIENT IS NOT ELIGIBLE)	NO L		
TSCE ELIGIBILITY COMPUTATION: (Take	en from 2024 Federal Poverty Lev	el 4/1/24)		
CIRCLE ONE IN EACH COLUMN BELOW			the patient's hous	ehold. Figure
the income of the patient and the patient's	responsible relative(s) before taxe	s and deductions.		
Family Size	Monthly Income	Yearly		
1	\$2,510		,120	
2	3,408		,896	
3	4,304		,648	
4	5,200		,400	
5	6,098		,176	
6	6,994		,928	
7	7,890		,680	
8	8,788		,456	
9	9,684		,208	
10	10,580	126	,960	
11	11,478		,736	
12	\$12,374	\$148	,488	1111 - 14
(For family units with more than 12 m	nembers, add \$898 monthly and \$	10,776 yearly for each	additional membe	r.)
My/our Monthly Income and Yearly Income	are less than or equal to the amo	unt circled above.		
TSCE CERTIFICATION:				
I/we understand that in order to be eligible Yearly Income must be less than or equal services.				
I/we understand and agree that this Agreer available to me/us for review, and that I/we	ment shall be governed by the ten shall fully cooperate with the Cou	ns and conditions set nty and Trauma Servic	forth in the TSCE, e Hospital in acco	which has been mad rdance with the TSC
I/WE, PATIENT OR RESPONSIBLE RELA INFORMATION I/WE HAVE GIVEN TO DE HEALTH SERVICES ON THE ABOVE DA' I/WE ALSO CERTIFY THAT I/WE HAVE D COST OF HEALTH SERVICES RECEIVEL LAWSUIT, LOS ANGELES COUNTY EME HOSPITAL AND PHYSICIAN CHARGES II SERVICES RELATED HERETO AS PERM	TERMINE MY/OUR TRAUMA SE TE(S) IS TRUE AND COMPLETE ISCLOSED ALL MY/OUR THIRD D. I/WE UNDERSTAND THAT IF RGENCY MEDICAL SERVICES, NCURRED DURING THE ABOVE	RVICE COUNTY ELIC TO THE BEST OF MY PARTY COVERAGE V I/WE HAVE A THIRD V SHALL HAVE THE RIC REFERENCED DATE	BIBILITY AS CIRC VOUR KNOWLED WHICH MAY PAY OR FIRST PARTY BHT TO RECOVE FOR SERVICE AN	LED ABÓVE FOR GE AND BELIEF. FOR ANY OF THE CLAIM OR R ALL REASONABL ID OTHER MEDICAI
Detient's Circulture		- W	_// Date	<u></u> *
Patient's Signature			Date	
Pagagarible Paletins (a) Ci	(Olaha adal) — 11 da a	e		<u></u>
Responsible Relative(s) Signature If patient unable to sign	(State relationship to patient)		Date	
TSCE Hospital Reviewer (Required to verif	y above information and signeture		_// Date	
LOOP LIOSPILAL MEMERAL (MEMAILED 10 MELLI	y above iniormation and signature	7	Date	

TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE) (U-1) AGREEMENT FORM

Hospital de servicios de Trauma/Medico	Numero de Paciente	e Fecha(s) de Servicio
AVISO: Los pacientes que no estan dispue	stos o se niegan a cooperar NO CALIFICAN	para el Programa de Servicios de Trauma para Indiç
INFORMACION DEL PACIENTE:		
Apellido	Nombre	Segundo nombre
Calle	Ciudad	Estado Codigo postal
	()	1 1
Numero del Sequro Social	Numero de Telefono	Fecha de Nacimiento
Pariente responsable del Paciente	Nombre(s)	Direction
Tiene cobertura de terceros (por ejempl	o, Seguro privado) que cubra parcial o to	otalmente los gastos de estos servicios medicos?
TSCE CALCULO DE ELEGIBILIDAD: (Obt	enido del NIVEL Federal de pobreza para	el año 2024 4/1/24)
MARQUE CON UN CIRCULO UN ELEME		de la familia basado en el numero de personas
Tamano en la familia	Ingresos mensuales	Ingresos anuales
1	\$2,510	\$30,120
2	3,408	40,896
3	4,304 5,200	51,648 62,400
5	6,098	73,176
6	6,994	83,928
7	7,890	94,680
8	8,788	105,456
9	9,684	116,208
10	10,580	126,960
11 12	11,478 \$12,374	137,736 \$148,488
(Para familias con mas de 1	2 miembros, anada \$898 mensuales y \$1	0,776 anuales por cada miembro adicional.)
	nenor que o igual a la cantidad indicada	
CERTIFICACION TSCE:	40000	
antenormente, mi/nuestro ingreso mens		ervicios de salud recibidos en las fecha(s) menci a la cantidad corrrespondiente al numero de po de salud.
Yo/Nosotros comprendo y estamos de mi/nuestra disposiciom para su revisio Hospital de acuerdo al TSCE.	acuerdo que este acuerdo debe regirse t n y que cooperaremos totalmente con l	pajo las condiciones expuestas en el TSCE, que los servicios del Condado y el Servicio de Trau
INFORMACION QUE HEMOS PROPORC DEL CONDADO COMO SE MENCIONO COMPLETO SEGUN MI LEAL SABER Y TERCEROS PARA QUE PUEDAN PAGAI QUE SI YO/NOSOTROS TENEMOS UNA MÉDICOS DEL CONDADO DE LOS ÁN HOSPITAL Y DEL MÉDICO INCURRIDO	CIONADO PARA DETERMINAR SI REUNO D'ANTERIORMENTE POR LOS SERVICIO O'ENTENDER. TAMBIEN DOY/DAMOS I R POR LOS GASTOS DE LOS SERVICIOS O TERCERA O PRIMERA DEMANDA O PLI IGELES, TENDRÁN EL DERECHO DE R OS DURANTE LA FECHA ARRIBA REFE	TE DAMOS FE BAJO PENA DE PERJURIO O LOS REQUISITOS PARA LOS SERVICIOS DE TE DE SALUD EN TALES FECHAS ES VERDAL FE QUE HE REVELADO MI/NUESTRA COBERTU MEDICOS RECIBIDOS. YO/NOSOTROS ENTENIEITO DEL PARTIDO, LOS SERVICIOS DE EMERCIECUPERAR TODOS LOS CARGOS RAZONABLE RIDA DEL SERVICIO Y OTROS SERVICIOS MEDITO INCLUYE LOS CARGOS DE FACTURA COMP
<u> </u>		
Firma del paciente		Fecha
Firma del familiar responsible Si el paciente no puede a firmar	Relacion al paciente	Fecha

ESTE DOCUMENTO O EL U-2 DEBE GUARDARSE CON LOS DATOS ECONOMICOS DEL PACIENTE

Fecha

El encargado de repasar los TSCE del Hospital (Necesario para verificar la information y firma precedentes)