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

TRAUMA SERVICE COUNTY ELIGIBILITY (TSCE) AGREEMENT

1 Trauma Service Hospital/Physician _____ 2 Medical Record Number _____ 3 Date(s) of Service ____/____/____

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 Patient'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 Income	19 Yearly Income
1	$2,510	$30,120
2	3,408	40,896
3	4,304	51,648
4	5,200	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	11,478	137,736
12	$12,374	$148,488

(For family units with more than 12 members, add $898 monthly and $10,776 yearly for each additional member.)
My/our Monthly Income and Yearly Income are less than or equal to the amount circled above.

TSCE CERTIFICATION:

I/we understand that in order to be eligible for TSCE for the health services received on the above date(s), my/our Monthly Income and Yearly Income must be less than or equal to the amounts corresponding to my/our Family Size. I/we will not be liable for these health services.

I/we understand and agree that this Agreement shall be governed by the terms and conditions set forth in the TSCE, which has been made available to me/us for review, and that I/we shall fully cooperate with the County and Trauma Service Hospital in accordance with the TSCE.

I/WE, PATIENT OR RESPONSIBLE RELATIVE(S), CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE GIVEN TO DETERMINE MY/OUR TRAUMA SERVICE COUNTY ELIGIBILITY AS CIRCLED ABOVE FOR HEALTH SERVICES ON THE ABOVE DATE(S) IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY THAT I/WE HAVE DISCLOSED ALL MY/OUR THIRD-PARTY COVERAGE WHICH MAY PAY FOR ANY OF THE COST OF HEALTH SERVICES RECEIVED. I/WE UNDERSTAND THAT IF I/WE HAVE A THIRD OR FIRST PARTY CLAIM OR LAWSUIT, LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES, SHALL HAVE THE RIGHT TO RECOVER ALL REASONABLE HOSPITAL AND PHYSICIAN CHARGES INCURRED DURING THE ABOVE REFERENCED DATE OF SERVICE AND OTHER MEDICAL SERVICES RELATED HERETO AS PERMITTED BY STATE LAW. THIS INCLUDES THE FULL BILLED CHARGES OF THE HOSPITAL.

20 Patient's Signature _____ 21 Date ____/____/____

22 Responsible Relative(s) Signature If patient unable to sign _____ 23 (State relationship to patient) _____ 24 Date ____/____/____

25 TSCE Hospital Reviewer (Required to verify above information and signature) _____ 26 Date ____/____/____

THIS FORM OR A U-2 MUST BE ON FILE IN THE PATIENT(S) FINANCIAL CHART

Trauma Center Provisions for Reimbursement MOA-Exhibit A

TSCE Revised 2/20/24jd

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

_____ _____ _____/_____/_____
Trauma Service Hospital/Physician | Medical Record Number | Date(s) of Service

NOTE: Patients unwilling or refusing to cooperate DO NOT qualify for the Trauma Services for Indigents Program.

PATIENT INFORMATION:

_____
Last | First | Middle

_____
Street | City | State | Zip

_____-_____-_____ ( )_____-_____ _____/_____/_____
Social Security Number | Telephone Number | Birth Date

_____
Patient's Responsible Relative(s) | Name(s) | 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)?

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.

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5	6,098	73,176
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7	7,890	94,680
8	8,788	105,456
9	9,684	116,208
10	10,580	126,960
11	11,478	137,736
12	$12,374	$148,488

(For family units with more than 12 members, add $898 monthly and $10,776 yearly for each additional member.)

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I/we understand and agree that this Agreement shall be governed by the terms and conditions set forth in the TSCE, which has been made available to me/us for review, and that I/we shall fully cooperate with the County and Trauma Service Hospital in accordance with the TSCE.

I/WE, PATIENT OR RESPONSIBLE RELATIVE(S), CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE GIVEN TO DETERMINE MY/OUR TRAUMA SERVICE COUNTY ELIGIBILITY AS CIRCLED ABOVE FOR HEALTH SERVICES ON THE ABOVE DATE(S) IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY THAT I/WE HAVE DISCLOSED ALL MY/OUR THIRD PARTY COVERAGE WHICH MAY PAY FOR ANY OF THE COST OF HEALTH SERVICES RECEIVED. I/WE UNDERSTAND THAT IF I/WE HAVE A THIRD OR FIRST PARTY CLAIM OR LAWSUIT, LOS ANGELES COUNTY EMERGENCY MEDICAL SERVICES, SHALL HAVE THE RIGHT TO RECOVER ALL REASONABLE HOSPITAL AND PHYSICIAN CHARGES INCURRED DURING THE ABOVE REFERENCED DATE OF SERVICE AND OTHER MEDICAL SERVICES RELATED HERETO AS PERMITTED BY STATE LAW. THIS INCLUDES THE FULL BILLED CHARGES OF THE HOSPITAL.

_____ _____/_____/_____
Patient's Signature | Date

_____ _____/_____/_____
Responsible Relative(s) Signature (State relationship to patient) | Date
If patient unable to sign

_____ _____/_____/_____
TSCE Hospital Reviewer (Required to verify above information and signature) | Date

THIS FORM OR A U-2 MUST BE ON FILE IN THE PATIENT(S) FINANCIAL CHART

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

_____ _____ _____/_____/_____
Hospital de servicios de Trauma/Medico Numero de Paciente Fecha(s) de Servicio

AVISO: Los pacientes que no estan dispuestos o se niegan a cooperar NO CALIFICAN para el Programa de Servicios de Trauma para Indigentes.

INFORMACION DEL PACIENTE:

_____
Apellido Nombre Segundo nombre

_____
Calle Ciudad Estado Codigo postal

_____-_____-_____ ( )_____-_____ _____/_____/_____
Numero del Sequro Social Numero de Telefono Fecha de Nacimiento

_____
Pariente responsable del Paciente Nombre(s) Direccion

Tiene cobertura de terceros (por ejemplo, Seguro privado) que cubra parcial o totalmente los gastos de estos servicios medicos?

SI ☐ NO ☐

TSCE CALCULO DE ELEGIBILIDAD: (Obtenido del NIVEL Federal de pobreza para el año 2024 4/1/24)

MARQUE CON UN CIRCULO UN ELEMENTO POR COLUMNA: Estime el tamano de la familia basado en el numero de personas en la casa del paciente. Estime el ingreso del paciente y los parientes responsables antes de impuestos y deducciones.

Tamano en la familia	Ingresos mensuales	Ingresos anuales
1	$2,510	$30,120
2	3,408	40,896
3	4,304	51,648
4	5,200	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	11,478	137,736
12	$12,374	$148,488

(Para familias con mas de 12 miembros, anada $898 mensuales y $10,776 anuales por cada miembro adicional.)

Mi/nuestro ingreso mensual y anual es menor que o igual a la cantidad indicada anteriormente

CERTIFICACION TSCE:

Yo/Nosotros comprendemos que para reuinar los requistos del TSCE para los servicios de salud recibidos en las fecha(s) mencionadas antenormente, mi/nuestro ingreso mensual y anual debe ser menos que o igual a la cantidad corrrespondiente al numero de personas en mi/nuestra familia. Yo/Nosotros no seremos reponsables por estos servicios de salud.

Yo/Nosotros comprendo y estamos de acuerdo que este acuerdo debe regirse bajo las condiciones expuestas en el TSCE, que estan a mi/nuestra disposiciom para su revision y que cooperaremos totalmente con los servicios del Condado y el Servicio de Trauma del Hospital de acuerdo al TSCE.

CON LA FIRMA, YO/NOSOTROS, EL PACIENTE O PARIENTES DEL PACIENTE DAMOS FE BAJO PENA DE PERJURIO QUE LA INFORMACION QUE HEMOS PROPORCIONADO PARA DETERMINAR SI REUNO LOS REQUISITOS PARA LOS SERVICIOS DE TRAUMA DEL CONDADO COMO SE MENCIONO ANTERIORMENTE POR LOS SERVICIOS DE SALUD EN TALES FECHAS ES VERDADERO Y COMPLETO SEGUN MI LEAL SABER Y ENTENDER. TAMBIEN DOY/DAMOS FE QUE HE REVELADO MI/NUESTRA COBERTURA DE TERCEROS PARA QUE PUEDAN PAGAR POR LOS GASTOS DE LOS SERVICIOS MEDICOS RECIBIDOS. YO/NOSOTROS ENTENDEMOS QUE SI YO/NOSOTROS TENEMOS UNA TERCERA O PRIMERA DEMANDA O PLEITO DEL PARTIDO, LOS SERVICIOS DE EMERGENCIA MÉDICOS DEL CONDADO DE LOS ÁNGELES, TENDRÁN EL DERECHO DE RECUPERAR TODOS LOS CARGOS RAZONABLES DEL HOSPITAL Y DEL MÉDICO INCURRIDOS DURANTE LA FECHA ARRIBA REFERIDA DEL SERVICIO Y OTROS SERVICIOS MÉDICOS RELACIONADOS A ESTO SEGÚN LO PERMITIDO POR LA LEY DEL ESTADO. ESTO INCLUYE LOS CARGOS DE FACTURA COMPLETOS DEL HOSPITAL.

_____ _____/_____/_____
Firma del paciente Fecha

_____ _____/_____/_____
Firma del familiar responsible Relacion al paciente Fecha
Si el paciente no puede a firmar

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

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