DSHS Uncompensated Trauma Care Application Information

1. Patent population
    a. Trauma Patients that meet Trauma Registry Criteria for CY2024 and MCHD received no compensation for the encounter.
        i. 108 Patients entered the Trauma Registry for CY2024
        ii. 6 patients met Uncompensated Care Criteria
            1. 2 of these patients were transferred
            2. 3 went to OR from the ED
            3. 1 was admitted to MCHD greater than 24 hours
            4. Total UCC=$124,823.52

Department of State Health Services (DSHS)
EMS/Trauma Systems (EMS/TS)
Uncompensated Trauma Care Application
Discharged Patients Data Calendar Year 2024

Due February 25, 2026

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

Hospital Name: Moore County Hospital DBA Memorial

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:

Jeff Turner _____

Name (print) Signature

Department of State Health Services (DSHS)
EMS/Trauma Systems (EMS/TS)
Uncompensated Trauma Care Application
Discharged Patients Data Calendar Year 2024

Due February 25, 2026

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

Hospital Name: Moore County Hospital DBA Memorial

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)
Uncompensated Trauma Care Application
Discharged Patients Data Calendar Year 2024

Due February 25, 2026

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

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:

John _____

Name (print) Signature

Department of State Health Services (DSHS)
EMS/Trauma Systems (EMS/TS)
Uncompensated Trauma Care Application
Discharged Patients Data Calendar Year 2024

Due February 25, 2026

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

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

Department of State Health Services (DSHS)
EMS/Trauma Systems (EMS/TS)
Uncompensated Trauma Care Application
Discharged Patients Data Calendar Year 2024

Due February 25, 2026

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

Hospital Name: Moore County Hospital District DBA Memorial

I, Dr. Lauren Knight, **Trauma Medical Director** for the hospital named above, acknowledge that a copy of this application was made available for my review.

Trauma Medical Director:

Name (print)	Signature	Date

I, Kelly Galloway, **Trauma Program Manager** for the hospital named above, acknowledge that a copy of this application was made available for my review.

Trauma Program Manager:

Name (print)	Signature	Date