

# **Community Memorial Hospital**

## **Cloquet, Minnesota**

### **Community Care Program**

**CMH**

Community  
Memorial Hospital

512 Skyline Boulevard  
Cloquet, MN 55720

**January 2017**  
**Community Care Program**  
**Guidelines for Assistance**

## Community Care Program Guidelines for Assistance

Poverty guidelines published by the U.S. Department of Health and Human Services for calendar year 2017 are as follows:

<b>Number of Family Members</b>	<b>Poverty guideline</b>	<b>200% of Poverty Guidelines</b>	<b>250% of Poverty Guidelines</b>
<b>1</b>	<b>\$12,060</b>	<b>\$24,120</b>	<b>\$30,150</b>
<b>2</b>	<b>\$16,240</b>	<b>\$32,480</b>	<b>\$40,600</b>
<b>3</b>	<b>\$20,420</b>	<b>\$40,840</b>	<b>\$51,050</b>
<b>4</b>	<b>\$24,600</b>	<b>\$49,200</b>	<b>\$61,500</b>
<b>5</b>	<b>\$28,780</b>	<b>\$57,560</b>	<b>\$71,950</b>
<b>6</b>	<b>\$32,960</b>	<b>\$65,920</b>	<b>\$82,400</b>
<b>7</b>	<b>\$37,140</b>	<b>\$74,280</b>	<b>\$92,850</b>
<b>8</b>	<b>\$41,320</b>	<b>\$82,640</b>	<b>\$103,300</b>

**Patient share 0%**

**Patient share: *Based on a sliding scale***

For families with more than eight members, add \$4,180 for each additional member.  
*Guidelines are subject to annual review and change.*

## **Purpose:**

In accordance with its Community Care Program, Community Memorial Hospital will provide uncompensated health care to patients that are determined to be unable to pay for services. This policy shall be applied in accordance with established procedures and no patient shall be denied uncompensated health care based upon race, creed, color, sex, national origin, or any other prejudice.

### **I. Eligibility**

All inpatient and outpatient accounts are eligible for uncompensated care.

Note: *Elective services or procedures are not eligible for the Community Care Program.*

Patient's eligibility will be based on the following information:

#### **A. The application includes:**

1. Income from all sources for individuals responsible for this obligation.
  - a. List gross income for the most recent three month period.
  - b. Listing of savings and checking accounts, certificates of deposit, stocks, and bonds.
  - c. A copy of the most recent federal income tax return or W-2 forms.
  - d. A copy of most recent statements for savings and checking accounts, certificates of deposit, stocks and bond accounts.
  - e. A copy of the letter of denial for Medical Assistance or be currently eligible for Medical Assistance.

**B.** All third party resources and non-hospital financial aid programs, including public assistance available through state Medicaid programs, must be exhausted before benefits can be requested.

**C.** Eligibility will be determined by comparing applicant's income to the Income Eligibility Guidelines.

### **II. Program Administration**

The Hospital's Community Care Program will be administered according to the following guidelines:

- A.** The application information will be reviewed and verified by Business Office personnel.
- B.** After reviewing income, Business Office personnel will determine if the patient/guarantor qualifies for benefits based on income and asset guidelines.
- C.** The patient/guarantor will be notified in writing of the eligibility determination.
- D.** Falsification of application or refusal to cooperate will result in denial of benefits.
- E.** The Hospital reserves the right to change benefit determination if the recipient's financial circumstances have changed.

## **NOTE**

Community Memorial Hospital may add criteria of its own to the above, which will allow additional persons to be eligible for uncompensated services.

Excessive medical expenses or other expenses beyond the control of the patient/guarantor would represent acceptable criteria for exceptions to this policy. Such criterion is considered by the facility when in the view of hospital management, payment and/or a deferred payment plan would create undue hardship.

## Community Care Program Requirements for Financial Disclosure

The following checklist of requested documents will assist in completing application and meet financial disclosure requirements.

1. APPLICATION FORM:  
COMPLETE AND RETURN
  
2. ACCOUNT INFORMATION:  
HOUSEHOLD FAMILY MEMBERS WITH CMH BILLS  

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3. MARITAL STATUS
  - i.  SINGLE  MARRIED  DIVORCED  SEPARATED
  - ii.  WIDOWED
  
4. INCOME VERIFICATION (COPIES)
  - i.  ALL INCOME SOURCES (*All family members*)
    1. COPIES OF PAY VOUCHERS (*LAST 3 MONTHS*)
    2. COPIES OF SOCIAL SECURITY PAYMENT VOUCHERS OR COPY OF BENEFIT AWARD LETTER
    3. COPIES OF PENSION PAYMENT VOUCHERS
  - ii.  FEDERAL TAX RETURN (*MOST RECENT SIGNED COPY*)
  - iii.  W-2 (*IF NO TAX RETURN*)
  
5. NUMBER OF EXEMPTIONS AS DETERMINED ON TAX RETURN
  - i.  \_\_\_\_\_
  
6. ASSET VERIFICATION (COPIES)
  - i.  CHECKING ACCOUNT (*MOST RECENT STATEMENT*)
  - ii.  CD'S (*MOST RECENT STATEMENT*)
  - iii.  STOCKS, BONDS (*MOST RECENT STATEMENT*)
  
7. MEDICAL ASSISTANCE LETTER (*COPIES*)
  - a. CONTACT COUNTY OFFICE TO APPLY FOR MA
  - b. CARLTON COUNTY – 879-4583
  - c. SEND DETERMINATION WITH APPLICATION FORM
    - i.  DENIAL LETTER
    - ii.  ELIGIBILITY
      1. MA # \_\_\_\_\_

**NOTE:**

Failure to submit requested information would result in automatic denial of Community Care benefits.

# Community Care Application

Name: Last First MI

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Address: Street City/State Zip

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**Social Security Number** **Home Phone**

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	Last 12 Months	Last 3 Months
Household Gross Wages		
Additional Income		
Total Income		

**MARITAL STATUS:**

SINGLE
  MARRIED
  DIVORCED
  SEPARATED
  WIDOWED

**EMPLOYER** \_\_\_\_\_

**CALCULATION OF EXEMPTIONS**

- a. Yourself
- b. Spouse
- c. First names of your dependent children who lived with you \_\_\_\_\_
- d. First names of your dependent children who do not live with you \_\_\_\_\_
- e.

<b>Other dependents:</b>			
(1) Name	(2) Relationship	(3) #of months lived in home	(4) Did you provide more than one-half of dependent's support?

**FINANCIAL INFORMATION**

Bank: \_\_\_\_\_ City: \_\_\_\_\_

Checking Balance: \_\_\_\_\_ Savings Balance: \_\_\_\_\_

**UNUSUAL EXPENSES**  
(bills greater than \$500)

To whom indebted	Type of Acct Medical, Credit Card, etc	Present Balance	Monthly Payment
1.			
2.			
3.			
4.			

A separate page may be used for listing of additional unusual expenses.

## **CERTIFICATION OF INFORMATION PROVIDED**

I certify that the above information is true and accurate to the best of my knowledge. If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action becomes appropriate.

DATE OF REQUEST \_\_\_\_\_

SIGNATURE OF APPLICANT \_\_\_\_\_

Return completed application and requested information to:

Community Memorial Hospital  
Patient Access Supervisor  
512 Skyline Blvd.  
Cloquet, MN 55720

If you have any questions, please contact our patient accounts department at (218) 878-7069  
or toll free (888)675-4641.