Community Memorial Hospital
Raiter Family Clinic

Cloquet, Minnesota

Community Care Program

Raiter Family Clinic
512 Skyline Boulevard
Cloquet, MN 55720

January 2025
Community Care Program
Guidelines for Assistance

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Guidelines for Assistance

Poverty guidelines published by the U.S. Department of Health and Human Services for calendar year 2025 are as follows:

Number of Family Members	Poverty guideline	200% of Poverty Guidelines	250% of Poverty Guidelines
1	$15,650	$31,300	$39,125
2	$21,150	$42,300	$52,875
3	$26,650	$53,300	$66,625
4	$32,150	$64,300	$80,375
5	$37,650	$75,300	$94,125
6	$43,150	$86,300	$107,875
7	$48,650	$97,300	$121,625
8	$54,150	$108,300	$135,375
		Patient share 0%	**Patient share:** ***Based on a sliding scale***

For families with more than eight members, add $5,500 for each additional member.
Guidelines are subject to annual review and change.

Purpose:

In accordance with its Community Care Program, Community Memorial Hospital/Raiter Family Clinic 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 prejudgment.

I. Eligibility

Only services provided and billed by Community Memorial Hospital/Raiter Family Clinic 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 and copies of savings and checking accounts, certificates of deposit, 401K/403B plans, and IRAs.
      c. A copy of the most recent federal income tax return or W-2 forms.
      d. 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 assistance can be requested.

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

II. Program Administration

The 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 assistance 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 a denial.

E. The facility reserves the right to change assistance determination if the recipient's financial circumstances have changed.

NOTE
Community Memorial Hospital/Raiter Family Clinic 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 criteria are 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/RFC BILLS
   ____
   ____
   ____
   ____

3. MARITAL STATUS
   i. [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] SEPARATED
   ii. [ ] WIDOWED

4. INCOME VERIFICATION (COPIES)
   i. [ ] ALL INCOME SOURCES *(ALL FAMILY MEMBERS OVER AGE 18)*
      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's from 2024 *(IF NO TAX RETURN)*

5. NUMBER OF HOUSEHOLD MEMBERS REPORTED ON TAX RETURN
   i. [ ] _________
   ii. [ ] _________ ADDITIONAL DEPENDENTS NOT ON TAX RETURN

6. ASSET VERIFICATION (COPIES)
   i. [ ] CHECKING AND SAVINGS ACCOUNTS *(MOST RECENT FULL STATEMENTS SHOWING DEPOSITS AND TRANSACTIONS)*
   ii. [ ] CD'S *(MOST RECENT STATEMENT)*
   iii. [ ] 401K/403B AND IRA STATEMENTS

7. MEDICAL ASSISTANCE LETTER *(COPIES)*
   a. CONTACT COUNTY OFFICE TO APPLY FOR MA
   b. CARLTON COUNTY – (218)879-4583
   c. *SEND DETERMINATION WITH APPLICATION FORM*
      i. [ ] DENIAL LETTER
      ii. [ ] ELIGIBILITY
         1. MA #______________________________

NOTE:
Failure to submit requested information will result in a denial of Community Care assistance.

Community Care Application

Name: Last	First	MI

Address: Street	City/State	Zip

Social Security Number	**Home Phone**

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

MARITAL STATUS:

[ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] SEPARATED [ ] WIDOWED

EMPLOYER ____

HOUSEHOLD MEMBERS AND DEPENDENTS

a. ☐ Yourself

b. ☐ Spouse, Name and Employer: ____

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.

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

UNUSUAL EXPENSES – Greater than $500

To whom indebted	Type of Acct Medical, Credit Card, etc.	Present Balance	Monthly Payment
1.			
2.			
3.			
4.			
5.			
6.			

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
Financial Counselor
512 Skyline Blvd.
Cloquet, MN 55720

If you have any questions, please contact our patient accounts department.
Last name A-K (218)878-7033 or email to tyamry@cmhmn.org
Last name L-Z (218)499-6721 or email to rmullen@cmhmn.org