



UNCOMPENSATED CARE PROGRAM

Upland Hills Health's Uncompensated Care program offers free or discounted care to those who have no means, or limited means, to pay for medical services (uninsured or underinsured). **Services provided at Upland Hills Health Hospital, Upland Hills Health Clinic in Mt. Horeb, Upland Hills Health Center, and clinic services over 200% FPL qualify for the Uncompensated Care program.**

Please complete all sections of the application and provide the documentation noted below:

- Copy of most recent State & Federal tax return
- Proof of current income – i.e. copy of last two (2) pay stubs
- Proof of your current mortgage balance, if applicable
- Copy of your property tax form(s) also referred to as your real estate tax bill, if you own property
- Proof of denial from the Badgercare/Wisconsin Medicaid program. If you didn't apply for Badgercare/Wisconsin Medicaid, please list reason why: _____
- **Fully complete, sign and date this application**

If you have questions about the application, contact our Patient Financial Counselors at (608) 930-8000 ext. 4145, Monday through Friday 8:00 a.m. to 4:30 p.m.

Return the completed application and supporting documentation to:

Upland Hills Health, Inc.

Attn: Patient Financial Counselor

800 Compassion Way

Dodgeville, WI 53533

UNCOMPENSATED CARE APPLICATION

Return application by:

1. General Information

Applicant:		Date of Birth:	
Spouse:		Date of Birth:	
Address:			
Telephone:			

2. Household Information – others living in the same household

Household Members:

Name:	Relationship:	Age:	Dependent:

(additional, please attach separate page)

3. Income Information

Income: Income is to be stated on a gross earning/receipts basis. Represents total cash receipts for all sources before taxes including, but not limited to, wages, public assistance payments, social security, unemployment or workers' compensation benefits, union strike pay, VA benefits, child support, alimony, pension income, insurance or annuity payments, interest, rental income, royalties, estate or trust incomes, compensation for injury claims.

Name of Employer or Source of Income (Applicant & Spouse)	Estimated Current Year Income	Start date/End date

***For verification purposes only, we will require a copy of your most current tax return and proof of current income listed above.**

**If you have any questions regarding this application,
 please call our Patient Financial Counselors at (608) 930-8000 ext. 4145.**

4. Assets Information

Bank Account Balances (Applicant & Spouse)					
Type	Location	Amount	Type	Location	Amount
Checking			Credit Union		
Checking			CD's or IRA's		
Savings			Other		

Property/Homestead					
Location:		Assessed Tax Value:		Mortgage Balance:	
Location:		Assessed Tax Value:		Mortgage Balance:	

Auto/Vehicle							
Make:		Year:		Estimated Value:		Loan Balance:	
Make:		Year:		Estimated Value:		Loan Balance:	
Make:		Year:		Estimated Value:		Loan Balance:	

Other Assets – Recreational Vehicles		
Type (Boat/Motorcycle/Snowmobile/RV/ATV/UTV/Other)	Estimated Value	Loan Balance

5. Expense Information

Monthly Expenses (If needed, please attach separate page)			
Rent		Food/Groceries	
Mortgage		Medications	
Utilities		Insurance Premiums	
Cable/Internet		Auto Loan Payment	
Phone (including cell)		Credit Card Payment	
Vehicle Fuel		Other Loan Payment	
Child Care		Other Loan Payment	

Please note any financial changes, such as job loss, divorce, death, or any other hardships:

I ATTEST that the information on this application is accurate to the best of my knowledge and truly represents my current financial situation; and I AUTHORIZE Upland Hills Health, Inc. to verify any information given on this application in the determination of my eligibility for Financial Assistance.

Patient/Responsible Party Signature

Date