Upland Hills Health

Please return the following information with your
Uncompensated Care Application:

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1. **A copy of your most recent State & Federal income tax forms AND (2) most recent pay stubs.** ***(If you did not file a tax form in the previous year, please note why you did not file.)***

2. **A copy of your property tax form(s) also referred to as your real estate tax bill, if you own property.**

3. **Proof of your current mortgage balance, if applicable.**

4. **Proof of denial from the Badgercare/Wisconsin Medicaid program.** ***If you didn't apply for Badgercare/Wisconsin Medicaid program, please list reason why on attached application.***

Return by: _____

Please sign and date your application and
send <u>all</u> the above information (along with your application)
in the enclosed self-addressed prepaid envelope.
All information is kept confidential

Upland Hills Health
800 Compassion Way - PO Box 800
Dodgeville, Wisconsin 53533
608/930-8000

UNCOMPENSATED CARE APPLICATION

Return application by: _____

Applicant: _____ M / F **Date of Birth:** _____
Spouse: _____ **Date of Birth:** _____
Address: _____
Street City State Zip
Telephone: Day _____ Evening _____ Cell _____

Household Members:

Name	*Age*	*Relationship*	*Dependent*	
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No

*If additional space is needed, please use back of page

Have You Applied for Any State/County Assistance Programs? Yes No
Date Applied: _____
Application Accepted: _____ Denied: _____

Was Health Insurance Available Through Employer and Waived as a Benefit? Yes No
Reason: _____

Have You Applied for Insurance Through the Marketplace? Yes No
If No, Reason Why: _____

INCOME: Represents total cash receipts for all sources before taxes including, but not limited to, wages, public assistance payments, social security, unemployment or worker's 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. Income is to be stated on a gross earnings/receipts basis.

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

Regular Monthly Expenses:

Rent	$	Alimony or Child Support	$
Mortgage Payment	$	Continuous Medication	$
Utilities:		Food/Groceries	$
Electric	$	Vehicle Fuel	$
Water/Sewer	$	Internet/Cable	$
Heat	$	Insurance:	
Garbage	$	Health	$
Phone	$	Life	$
Auto Loan Payments	$	Home	$
Other Loan Payments	$	Vehicle	$
Credit Card Payments	$	Monthly Payment - Child Care	$

Assets-Savings (Patient & Spouse Combined)			**Liabilities (Bills & Debts Combined)**		
Type	*Location*	*Amount*	*Type*	*Location*	*Amount*
Checking			Mortgage		
Savings			Credit Union Loans		
Credit Union/Bank			Bank Loans		
CD's			Credit Cards		
IRA's			Auto Loans		
Other			Other Debts		

Assets - Property

Homestead: Location: _____

Assessed Taxable Value: $_____ Mortgage Due: $ _____

Other Property: Location: _____

Assessed Taxable Value: $_____ Mortgage Due: $ _____

Assets - Auto or Trucks

Year	*Make*	*Estimated Value $*	*Loan Balance $*

Other Assets - Recreational Vehicles

Year	*Make*	*Estimated Value $*	*Loan Balance $*
	Snowmobile		
	Boat/Motor		
	Motorcycle		
	3 Wheeler/Quad		
	Motor home		
	Other RV		

* Did you file taxes last year? Yes No

If no, please describe why you did not file:_____

_____

Please describe any financial changes from previous calendar year to present time (such as job loss/ unemployment, etc.)

I ATTEST that the above information is accurate to the best of my knowledge and truly represents my current financial status; and I AUTHORIZE Upland Hills Health, Inc., of Dodgeville, Wisconsin to verify any information given on this application in the determination of my eligibility for a community care allowance.

_____ _____

Patient or Responsible Party Date

NOTE: Proof of current income must be provided at time of application, plus copies of your most recently filed Federal & State Income Tax Forms.