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 – ie. 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 Benefit Specialists 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 Benefit Specialist
800 Compassion Way
Dodgeville, WI 53533

Updated: October 2023

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

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:	
Name:		Relationship:		Age:		Dependent:	
Name:		Relationship:		Age:		Dependent:	
Name:		Relationship:		Age:		Dependent:	
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 Benefit Specialists at 608-930-8000 ext. 4145.**

Updated: October 2023

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			

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