SLIDING FEE SCALE PROGRAM

Upland Hills Health's Sliding Fee Scale (SFS) program offers free or discounted care to those who have no means, or limited means, to pay for their medical services (uninsured or underinsured). **Services provided at Upland Hills Health Clinic in Spring Green, Highland, Montfort, Barneveld, Mineral Point Medical Center of Upland Hills Health and Dodgeville Medical Center of Upland Hills Health qualify for the SFS program.**

Federal Poverty Guidelines:

Family Size	1	2	3	4	5	6	7	8
Yearly Income	$0- $15,060	$0- $20,440	$0- $25,820	$0- $31,200	$0- $36,580	$0- $41,960	$0- $47,340	$0- $52,720

If your family size and yearly household income fall in the scale noted above, this means you are at or below 200% of the federal poverty level (FPL), and you qualify for free **medically necessary services. Please complete sections 1-3 of the application and provide the following supporting documentation:**

- Copy of most recent State & Federal tax return
- Proof of current income – ie. copy of last two (2) pay stubs
- Sign and date this application

If your family size and yearly household income exceed the amounts noted in the scale above, you are above 200% FPL, and you may qualify for discounted **medically necessary services**. Please ask about Upland Hills Health's Uncompensated Care program or visit www.uplandhillshealth.org/patient-visitor/patient-resources/billing-questions.

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

SLIDING FEE SCALE APPLICATION

Return application by:

Applicants applying for the Sliding Fee Scale at or below 200% of the Federal Poverty Level (FPL), complete sections 1-3.

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.**

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before discount is approved.

Name (Print) Date

Signature Date

If you have any questions regarding this application, please call our Patient Benefit Specialists at 608-930-8000 ext. 4145.