

MILE BLUFF MEDICAL CENTER, INC
FINANCIAL ASSISTANCE PROGRAMS APPLICATION

Completed application must be returned along with **all** supporting documentation

Given by: _____ Date: _____

FINANCIAL ASSISTANCE PROGRAM SLIDING FEE SCALE

Mile Bluff's Sliding Fee Scale Program offers free or discounted care to those who have no means, or limited means, to pay for their emergency or medically necessary medical services (uninsured or underinsured). Income guidelines are based on the Federal Poverty Level Guidelines. This information can be found at <https://aspe.hhs.gov/poverty-guidelines>

If your family size and yearly household income fall in the scale noted above, you MAY qualify for free medically necessary services. Even if you do not fall within the scale, you may still qualify for discounted services, so you may still apply. Please complete all sections of the application & provide the following supporting documentation:

- Copy of the Federal tax return Form 1040, and all attached Schedules from the most recent tax year.
- Most recent W2 or 1099 or Social Security income statement
- Current proof of Income (copy of two most recent pay stubs) or written income verification from an employer if paid in cash.
- Proof of other income, including but not limited to, unemployment, worker compensation, alimony, trust income, Annuities/IRA/401K/Pensions disbursements, and veteran benefits.

An application is not a guarantee of discounted services; application is subject to review by the Financial Assistance Committee. If you have questions about payment plans or financial assistance, please contact one of our Financial Counselors at (608) 847-1497, (608) 847-9796, Monday through Friday 8am-4:30pm.

Return to: Mile Bluff Medical Center

Attn: Financial Counselors

1050 Division St.

Mauston, WI 53948

1. Applicant's General Information

Last Name _____ First Name _____ MI _____

Date of Birth _____ Social Security Number _____ Daytime Phone _____

Address _____

City _____ State _____ Zip _____

Mailing Address if Different than Physical Address _____

Employed: ____ Employed FT ____ Employed PT ____ Unemployed ____ Retired ____ Disabled

*If applying for disability benefits, please provide a letter from your provider explaining your disability

Employer: _____ Phone: _____

Pay cycle? (circle one) weekly biweekly monthly

How long have you worked for this employer? _____ Current Hourly Wage: _____

Is Insurance available to you through your employer? Yes No

2. Spouse/Domestic Partner's General Information

Last Name _____ First Name _____ MI _____

Date of Birth _____ Social Security Number _____ Daytime Phone _____

Address _____

City _____ State _____ Zip _____

Mailing Address if Different than Physical Address _____

Employed: ____ Employed FT ____ Employed PT ____ Unemployed ____ Retired ____ Disabled

*If applying for disability benefits, please provide a letter from your provider explaining your disability

Employer: _____ Phone: _____

Pay cycle? (circle one) weekly biweekly monthly

How long have you worked for this employer? _____ Current Hourly Wage: _____

Is Insurance available to you through your employer? Yes No

3. Dependents Living Same Household

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

Name _____ Relationship _____ Age _____

4. Income Information

***Please list the amount of monthly gross income in your household from each category that applies.

Wages _____ Social Security _____ Unemployment _____

****Please include both your information and your spouse's information**

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT

(SIGNATURE)

(DATE)