MARSHFIELD MEDICAL CENTER-DICKINSON

Notice of Availability of Uncompensated Care

It is the policy of Dickinson County Healthcare System to make available uncompensated care for eligible persons needing care who are unable to pay for hospital services. You may be eligible for free or reduced cost services depending upon your income and the size of your family based upon the following guidelines:

Carefully follow instructions on page 2.

Family Size*	**Annual Income****						
1	$0	14,580	18,225	21,870	25,515	29,160	Over
2	0	19,720	24,650	29,580	34,510	39,440	Over
3	0	24,860	31,075	37,290	43,505	49,720	Over
4	0	30,000	37,500	45,000	52,500	60,000	Over
5	0	35,140	43,925	52,710	61,495	70,280	Over
6	0	40,280	50,350	60,420	70,490	80,560	Over
7	0	45,420	56,775	68,130	79,485	90,840	Over
8	0	50,560	63,200	75,840	88,480	101,120	Over
Disc Amount		100%	80%	60%	40%	20%	0%

For family units with more than 8 members add $5,140 for each additional member

*A family member is defined as one who is eligible to be claimed on a Federal Income Tax return, including children under 18 or full-time students to age 24.

**Income is defined as total receipts before taxes, from all sources, including wages, self-employment income, retirement, public assistance, social security, unemployment or workmen's compensation, stroke benefits, alimony, child support, military allotments, dividends, interest, & rental income Incomes equal to exactly the amounts indicated fall into the preceding discount category.

Scale Effective at MMC-D January 1, 2023

All information provided on the application is subject to verification. Each step outlined below must be completed. If it is not, your application will be denied. If any information is found to be false, the current and all future applications for Uncompensated Care will be denied.

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THE APPLICANT MUST:

1. Make an application for Medical Assistance with your local Department of Social Services. For Wisconsin go to www.access.wi.gov
   For Michigan go to www.mibridges.michigan.gov
2. Provide Dickinson County Healthcare System's Patient Accounts Department with a photocopy of your Medical Assistance Determination Form provided by the Department of Social Services.

3. Provide proof of entire "family income." This may be in the form of photocopies of pay stubs, income tax forms, and W-2 forms.

4. Make full payment of the patient liability due if you are eligible for partial reduction of your hospital bill under current guidelines.

5. Notify the Hospital immediately of any change in financial status or availability of insurance coverage.

If you feel that you are eligible for Uncompensated Care and wish to request it, please return attached application. It will be considered complete when we receive a copy of your Medicaid denial and proof of income. A written determination of eligibility will be made when your application is complete.

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Application For Uncompensated Care

Guarantor Name _____

Address _____

Telephone Number _____

	Guarantor	Other Employed Family Member
Social Security #		
Occupation		
Employer		
Employer Address		
Employer Phone		

Services for which I am applying for Uncompensated Care:

Date:	Account Number:	Patient:

Members of household:

Name	Relationship	Date of Birth

Family Income: All items listed refer to the entire family unit. Attach supporting documentation for each.

	Income last 3 months	Last 12 months
Entire Family Unit Wages		
Unemployment Compensation		
Workers Compensation		
Child Support/Alimony		
Public Assistance		
Social Security/Pension		
Other		
Total		

I certify that the above information is true and accurate to the best of my knowledge. I have read and agree to comply with all terms and requirements set forth in the Notice of Availability of Uncompensated Care.

Signature of Applicant _____ **Date** _____

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Determination of Eligibility for Uncompensated Care

Date: _____

Applicant: _____

Date of birth: _____

After reviewing your application for Uncompensated Care through Dickinson County Healthcare System, the following determination has been made:

_____ **Pended** please provide the following that is checked:

_____ _____ Tax returns to include 1040, W2's and/or 1099 forms

_____ Most current check stub from all employment and family members for past and present from January 1, ____ to current. Must show year to date gross income or provide all check stubs if no year to date shown.

_____ Verification of Medicaid denial from the Department of Human Services
For Michigan go to www.mibridges.michigan.gov
For Wisconsin go to www.access.wi.gov

_____ All verification of any income other than from employment.
Income is defined as total receipts before taxes from all sources including wages, self-employment, retirement, public assistance, social security, unemployment or workmen's compensation, stroke benefits, alimony, child support, military allotments, dividends, interest, rental income and personal indemnity plan reimbursement.

_____ **Approved**
A discount of _____% will be applied.
(Note: Eligibility does not apply to elective procedures.)

Effective date _____ through _____

_____ **Denied** you do not meet the following eligibility requirements.

If a balance remains or your Application has been denied, please call the Patient Accounts Department at 776-5666 to make payment arrangements.

Eligibility for Uncompensated Care is determined every six months. If you return to Dickinson County Healthcare System after _____, you will need to contact the Patient Accounts Department to reapply.

Sincerely,

Patient Financial Counseling
(906)776-5666 8 - 4 pm Monday - Friday