



Corporate Office
506 Campus Drive
Hancock, MI 49930
Phone: (906) 483-1705
Fax: (906) 483-1394

Sliding Fee Program

What is the Sliding Fee Program? The Sliding Fee Program is a federally funded program that provides a discount to patients who are uninsured or underinsured. This program allows qualifying patients to receive Medical, Dental and Behavioral Health services at Upper Great Lakes Family Health Centers (UGL) at a discounted fee after any insurance, if applicable, has processed the claim. There is a minimum co-payment due at the time of service for all discounted services received.

Who is eligible for the Sliding Fee Program? Uninsured and underinsured patients may qualify for the Sliding Fee Program. Patients currently enrolled in other discounted health care programs such as the Western Upper Peninsula Health Access Coalition (WUPHAC), Marquette County Access Coalition or local Charitable Care Programs are encouraged to apply. Federal guidelines require us to take household size and household income into consideration when determining an applicant's eligibility.

Where does the Sliding Fee Program apply? The Sliding Fee Program applies to qualifying patients who receive services at any of these Upper Great Lakes Family Health Center sites:

****Calumet**

56720 Calumet Ave.
Calumet, MI 49913
(906) 483-1177

Gwinn

135 East M-35
Gwinn, MI 49841
(906) 346-9275

***Hancock**

500 Campus Dr.
Hancock, MI 49930
Family Practice (906) 483-1060
Pediatrics (906) 483-1700
OB/GYN (906) 483-1050

Houghton

600 MacInnes Dr.
Houghton, MI 49931
(906) 483-1860

Iron River

1500 W. Ice Lake Rd.
Iron River, MI 49935
(906) 265-5378

Lake Linden

945 Ninth St.
Lake Linden, MI 49945
(906) 483-1030

Menominee

1110 10th Avenue
Menominee, MI 49858
(906) 290-5000

Ontonagon

751 S. Seventh St.
Ontonagon, MI 49953
(906) 884-4120

****Sawyer**

301 Explorer St.
Gwinn, MI 49841
(906) 346-9275

***Hancock Location:** Includes clinic services received in Family Practice, Pediatrics and OB/Gyn.

****Dental Services** available at these locations; Calumet and Sawyer.

When should you apply for the Sliding Fee Program? You should apply immediately to see if you qualify for the Sliding Fee Program. If approved for the program, you will be required to renew your application and



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information on an annual basis. If you are not approved for the program, you are encouraged to contact us if you have a significant change in income or family size as we may be able to re-evaluate your information.

How can I apply for the Sliding Fee Program? You may apply for the Sliding Fee Program by submitting the following:

- * Completed and signed Sliding Fee Program Application (enclosed)
- * Proof of Income
 - Income is defined as any money received whether cash, check, or direct deposit used to support your household. Income can include; wages, unemployment, pension, social security, disability, child support, gambling winnings and cash payment for services rendered or payment for other reasons.
 - Households claiming zero income will be required to schedule an appointment with one of our eligibility staff members to determine if a discount can be determined.
- * Copy of current driver's license

Enclosed is an application for the Sliding Fee Program. Please complete, sign and return your application and proof of income to the location of your preferred health center above. Once received, your completed application will be reviewed by a member of our staff who will then send you a letter regarding your eligibility. **Keep in mind, if you are accepted into the Sliding Fee program, discounts will only apply to services received after you've been approved.**

Please note: All of the above information must be received in order to process your application. Submitting incomplete or partial information will delay a decision until additional requested information is received. Until you receive a letter indicating you have qualified for a discount, you are responsible for 100% of all charges.

Sincerely,

Upper Great Lakes Family Health Center Staff

*Please note: If approved for the Sliding Fee Program, **limited** Diagnostic and Radiology services are available to you at a discounted rate*



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Sliding Fee Application

Head of Household _____
 (please print) Last Name First Name Middle Initial

Mailing Address _____
 Street City Zip

Telephone () _____ Date of Birth _____

Social Security Number _____

Marital Status Married Single Widowed Separated Divorced

Household Members

Please print information below for ALL other persons living in your household

Full Name	Date of Birth	Relationship	Insurance Y/N

Insurance Name _____ Subscriber name _____

Group Number _____



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Income Verification

Please provide proof of income in the form of prior year tax return, check stubs, bank statements, or social security statements.

- Income is defined as any money received whether cash, check, or direct deposit used to support your household. Income can include; wages, unemployment, pension, social security, disability, child support, gambling winnings and cash payment for services rendered or payment for other reasons.

I verify that this information presented in this application to be true and accurate to the best of my knowledge and my signature below verifies that I am applying for a Sliding Fee Program discount. Furthermore, I understand that I am responsible for 100% of any charges incurred prior to being deemed eligible to receive a discount through the Sliding Fee Program.

Signature _____ Date _____
Head of household

Signature _____ Date _____
Spouse or other adult household member



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For Internal Use Only

Attach copies of the applicable documents for both the patient/guarantor and spouse (please submit only copies; no original documents):

Documents Required	Received	Additional Notes
A completed, signed and dated application (Signed by both head of household and spouse)		
Government ID (Driver's License)		
Proof of Income (All household members) Acceptable Proof of Income includes: <ul style="list-style-type: none"> • Most recent tax return • Last two pay stubs • Social Security form • Past two months of bank statements (It needs to show Social Security deposit and a signed note stating what amounts are taken out for Medicare Part B & D) • Other income documents and past two months of bank statements If no Income: <ul style="list-style-type: none"> • If no income, letter explaining their source of paid expenses (Ex. How do they receive food/housing?) 		
<p style="text-align: center;">*** All household members must turn in their income information if they have any. If stated there is no income, they will need to provide a letter explain their source of paid expenses (how do they receive food/housing) ***</p>		

Processed By: _____ Date: _____
Financial Counselor

Eligibility Determination: () Yes () No Discount: _____%

If denied, state reason: _____