



Calumet
56720 Calumet Avenue
Calumet, MI 49913
(906) 483-1177

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

Hancock
500 Campus Drive
Hancock, MI 49930

- Family Practice
(906) 483-1060
- Pediatrics
(906) 483-1700
- Obstetrics & Gynecology
(906) 483-1050

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

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

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

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

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

Sawyer
301 Explorer Street
Gwinn, MI 49841
(906) 346-9275

Marquette
1414 W. Fair Avenue
Marquette, MI 49855
(906) 449-2900

Dear Students,

On behalf of the Upper Great Lakes Health Center (UGL), congratulations on becoming a new Husky! As the campus medical and wellness home for students at MTU, we offer services specifically for students conveniently located right on campus in the Student Development Center (SDC).

UGL's [Houghton Family Health Center](#) and [UP Health System – Portage](#) have partnered to provide [Michigan Tech's student health services](#). Here are some of the services we offer.

- Primary Care Services
- Online Scheduling - <https://uglhealth.org/schedule-a-visit/>
- Women's Health
- Birth Control/Sexual Health/STI
- (HRT) Hormone Replacement Therapy
- Behavioral Health/LMSW
- ADHD Care/Referrals
- Physical/Occupational Therapy
- (OMT) Osteopathic Manipulation Treatment
- Pharmacy
- Labs
- X-Ray
- Sports Medicine Services
- Care for Acute Injuries or illnesses Including Same Day Walk – In Availability
- Allergy Injections/Medication Administration
- Annual Flu Shots and other Routine Immunizations
- Coordination of Student Healthcare with other Healthcare Providers
- Referral to Outside Specialists for Specific Health Needs

This time of transition is exciting and sometimes unsettling. You may be navigating the healthcare system for the first time without your parents, and you can trust that we understand what that is like for each of you. I assure you that the health center staff is prepared to serve as the student's health and wellness home away from home.

We have included our new patient packet to help gather needed health information and allow for a seamless transition of care to UGL. If you have any questions, please feel free to call our clinic directly at (906) 483-1860.

Sincerely,

UGL Staff



600 MacInnes Drive
Houghton, MI 49931

(906) 483-1860
uglhealth.org



Meet Our Providers



Zainab Almahrous, MD
Internal Medicine



Karen DeYoung, DO
Family Medicine



Zachariah DeYoung, MD
Family Medicine



Stephanie McKenzie, PA-C
Family Medicine



Zachary Roloff, PA-C
Internal Medicine



Tayler Ruby, FNP-C
Family Medicine



Melissa Vertin, PA-C
Family Medicine



**Christiann Rosemurgy,
CNM, WHNP-BC**
Women's Health

Call (906) 483-1860 or visit uglhealth.org/schedule-a-visit/ to schedule your appointment today!

UPPER GREAT LAKES FAMILY HEALTH CENTER-REGISTRATION FORM

General Information

First Name:		Middle Initial:	Last Name:	
Mailing Address:		City:	State:	Zip:
Physical Address:		City:	State:	Zip:
County:	Home Phone:	Cell Phone:	Work Phone:	
Birthdate:	Social Security #: _____ - _____	Do you have paperwork about your end of life wishes? __Yes __No		
Email address:		Do you want to participate in our Patient Portal? __Yes __No		
<i>What is the best way to reach you?</i> <input type="checkbox"/> cell phone <input type="checkbox"/> home phone <input type="checkbox"/> text <input type="checkbox"/> email <input type="checkbox"/> other _____ <i>Can we text you appointment reminders?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No				

Marital status?	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
Do you work in Agriculture?	<input type="checkbox"/> Migrant Worker <input type="checkbox"/> Seasonal Worker <input type="checkbox"/> None			
Employer:	Occupation:	Do you work: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired		

Our Policy

It is the policy of UGL to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Race:	<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other: <input type="checkbox"/> Native American/ Alaska Native – Tribal Member: <input type="checkbox"/> Yes <input type="checkbox"/> No Descendent: <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Tribe: _____					
Ethnicity:	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Other: _____			Preferred Language:		
Are you a veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you homeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Sexual Orientation:	<input type="checkbox"/> Straight	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Lesbian/Gay	<input type="checkbox"/> Something Else	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Choose not to disclose
Gender Identity:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Transgender Male	<input type="checkbox"/> Transgender Female (male to female)	<input type="checkbox"/> Other	<input type="checkbox"/> Choose not to disclose

Insurance Information

Do you currently have health insurance? Yes No (Please also send a copy of insurance card(s) to billing@uglhealth.org)

Dental Insurance? Yes No

If no we will schedule an appointment with our outreach and enrollment team to help you.

Name of Individual Responsible for the Bill:		Relationship:	
Subscriber No.:	Group No.:		
Policyholder's Name:	Birthdate:	Social Security #: _____ - _____	
Mailing Address:	City:	State:	Zip:
Phone:	Which PHARMACY do you use?		Ph#:

Income Information

Federal Regulations require that we report the *combined total* of all household members' income for those seeking care at UGL. We ask your cooperation in indicating the following: Total Number in Household _____

Your yearly combined household gross income? _____ Decline to answer _____

Even if you have insurance, you may qualify for UGL's sliding fee scale, which offers discounted fees for services. Do you want to apply to see your qualification? Yes No

Emergency Contact Information

Name:		Relationship:	
Mailing Address:		City:	State: Zip:
Home Phone:	Cell Phone:	Work Phone:	

Thank you for completing this application form and for your interest in joining the Upper Great Lakes Family Health Center, Inc. community of care.



PATIENT CONSENT TO VERBALLY DISCUSS INFORMATION

I hereby agree and consent to Upper Great Lakes Family Health Center staff verbally discussing medical and financial information about my healthcare with the following individual(s):

PLEASE PRINT: First and Last Name

Relationship to Patient

PLEASE PRINT: First and Last Name

Relationship to Patient

PLEASE PRINT: First and Last Name

Relationship to Patient

PLEASE PRINT: First and Last Name

Relationship to Patient

PLEASE PRINT: First and Last Name

Relationship to Patient

This consent is valid for one year from date of signature unless I notify Upper Great Lakes Family Health Center in writing of my withdrawal.

I hereby release Upper Great Lakes Family Health Center from all legal responsibility or liability that may arise from the acts that I have authorized above.

PLEASE PRINT: Patient's First and Last Name

Patient's DOB

Patients Signature

Date

*If patient is less than 18 years of age, then permission is granted by the following parent and/or legal guardian of above-named minor:

PLEASE PRINT: Parent or Guardian's First and Last Name

Date

*** Parent or Guardian's Signature**



Patient Authorization for Disclosure of Health Information

(Patient Name) (Date of Birth) (Maiden/Previous Name) (Patient Phone #)

Records to Be Disclosed From:

Disclose Records To:

Organization/ Individual:
Address:
Phone:
Fax:

Organization/ Individual:
Address:
Phone:
Fax:

Covering the Period of Healthcare from:

Date(s): to

OR

All Past/Present Health Information

Information to Be Disclosed:

Purpose of Disclosure (check all that apply):

Disclosure Format:

- Entire Health Record
Medical Progress Note(s)
Immunization Record
Laboratory Report(s)
Radiology Report(s)
Dental Record(s)
Dental Imaging
Other:
At the Request of Patient
Continued Care
Attorney/Legal
Insurance
Worker's Comp
Relocating
Personal Use
Other:
Fax
Electronic (Patient Portal)
Paper-Pickup in Person
Paper-US Mail
Other:

By signing this authorization form, I understand that:

- The information to be disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or other communicable diseases. It may also include information about behavioral or mental health services, treatment and/or testing for substance use disorders, and genetic testing.
1) Any sensitive information listed above I wish to be EXCLUDED will be indicated here:
Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 301 Explorer Street, Gwinn, MI 49841. Revocation will not apply to information that has already been disclosed in response to this authorization.
Unless otherwise revoked, this authorization will expire on the following date/event/condition: . If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules

(Patient or Authorized Representative Signature) (Date)

Print Name Relationship to Patient (if applicable)

Submit the completed form to UGL Medical Records via the email or fax listed at the top of this form.

(For Office Use Only): Received On: Verified By:



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 amount 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

Marquette

1414 W. Fair Ave, Suite 249
Marquette, MI 49855
(906)-449-2900



Corporate Office

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

***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 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 provide a signed statement explaining the current financial situation so staff members are able to determine if a discount can be approved.

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. If you have further questions please contact a Financial Counselor at 906-483-1130 opt. 2. Once received, your completed application will be reviewed by a member of our staff who will then send you a letter regarding your eligibility.

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*

Revised 01/15/2026



Corporate Office

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

Sliding Fee Application

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

Mailing Address _____
Street City Zip

Telephone __ (____) _____ Date of Birth _____

Pharmacy _____ 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

*Medical Insurance Name _____ Subscriber Name _____

Policy Number _____ Group Number _____



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*Dental Insurance Name _____ Subscriber Name _____
Policy Number _____ Group Number _____

Income Verification

Please provide proof of income for all members living within your household. Supporting documentation must show gross pay (total of income before any deductions), cover 4 consecutive weeks of pay and indicate the length of the pay period covered. Examples include:

- Most Recent Tax Return
- Check Stubs
- Social Security Income*
- Disability Income
- Child Support
- Unemployment Income
- Pension
- Retirement Income

*If you receive Social Security benefits, please provide the letter you received from the Social Security Administration stating the amount you receive each month. If you are unable to provide the letter, we will accept your last two months of bank statements showing the deposit along with a signed note stating the amount that is taken out for Medicare Part B & D.

Households claiming zero income will be required to schedule an appointment with a Financial Counselor to determine eligibility.

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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**Upper Great Lakes Family Health Center, INC
 DEPARTMENT OF HEALTH & HUMAN SERVICES POVERTY GUIDELINES**

EFFECTIVE 01/15/2026

		Less than A	More than A Less than B	More than B Less than C	More than C Less than D	More than D
Medical Services		\$25 Nominal Charge*	\$50 Discounted Fee*	\$75 Discounted Fee*	\$100 Discounted Fee*	No Discount
Behavioral Health		\$10 Nominal Charge	\$30 Discounted Fee	\$50 Discounted Fee	\$70 Discounted Fee	No Discount
Dental Services		\$30 Nominal Charge*	40% of Total Charge*	50% of Total Charge*	60% of Total Charge*	No Discount
Pharmacy		\$1.50 Nominal Charge**	\$2.00 Nominal Charge**	\$2.50 Nominal Charge**	\$3.00 Nominal Charge**	No Discount
HOUSEHOLD SIZE		A	B	C	D	E
	YEAR	15,960.00	19,950	27,930	31,920	31,920.01
1	MONTH	1,330.00	1,663	2,328	2,660	2,660.01
	WEEK	306.92	384	537	614	614.01
	YEAR	21,640.00	27,050	37,870	43,280	43,280.01
2	MONTH	1,803.33	2,254	3,156	3,607	3,607.01
	WEEK	416.15	520	728	832	832.01
	YEAR	27,320.00	34,150	47,810	54,640	54,640.01
3	MONTH	2,276.67	2,846	3,984	4,553	4,553.01
	WEEK	525.38	657	919	1,051	1,051.01
	YEAR	33,000.00	41,250	57,750	66,000	66,000.01
4	MONTH	2,750.00	3,438	4,813	5,500	5,500.01
	WEEK	634.62	793	1,111	1,269	1,269.01
	YEAR	38,680.00	48,350	67,690	77,360	77,360.01
5	MONTH	3,223.33	4,029	5,641	6,447	6,447.01
	WEEK	743.85	930	1,302	1,488	1,488.01
	YEAR	44,360.00	55,450	77,630	88,720	88,720.01
6	MONTH	3,696.67	4,621	6,469	7,393	7,393.01
	WEEK	853.08	1,066	1,493	1,706	1,706.01
	YEAR	50,040.00	62,550	87,570	100,080	100,080.01
7	MONTH	4,170.00	5,213	7,298	8,340	8,340.01
	WEEK	962.31	1,203	1,684	1,925	1,925.01
	YEAR	55,720.00	69,650	97,510	111,440	111,440.01
8	MONTH	4,643.33	5,804	8,126	9,287	9,287.01
	WEEK	1,071.54	1,339	1,875	2,143	2,143.01
For each add'l person, add	YEAR	5,680.00	7,100	9,940	11,360	11,360.01
	MONTH	473.33	592	828	947	947.01
	WEEK	109.23	137	191	218	218.01

Upper Great Lakes Family Health Centers defines "household" as: ALL THE PERSONS WHO OCCUPY A HOUSING UNIT WHETHER THEY ARE RELATED TO EACH OTHER OR NOT.

REVS'D 02/03/26

UGL defines "income" as TOTAL CASH RECEIPTS (WAGES, SALARIES, PUBLIC ASSISTANCE/ UNEMPLOYMENT/RETIREMENT PAYMENTS, SOCIAL SECURITY, ALIMONY, CHILD SUPPORT.) BEFORE TAXES. However, income does not include non-cash benefits (food stamps, school lunches, or food/trent in lieu of wages). Income include gifts.

***Services that include materials, devices and/or lab costs will be in addition to the nominal fee.**

**** Pharmacy nominal charge is paid at the participating Pharmacy. Additional fees may apply per individual Pharmacy.**