Patient Business Services
10920 Wilshire Blvd #1600
Los Angeles, CA 90024-6502

ATTACHMENT B

Date: **Due Date:**

Patient Name:
MRN /HAR#
Balance Due

Dear Mr./Ms.

Thank you for choosing UCLA Health as your healthcare provider.
All patients must apply for Medi-Cal before Charity Care funds are considered.

In order to determine any financial assistance, the following information must be received in our office within 15 days from the date of this letter.

If all the requested information is not received within the allotted time the request for financial assistance will be closed. **You are financially responsible for the outstanding balance until your application is reviewed pending approval or denial.**

- ☐ Last two paycheck stubs (including year to date earnings)
- ☐ Proof of Child support / Alimony income/payment (if applicable).
- ☐ Proof of Disability / Unemployment income (if applicable).
- ☐ Notarized statement of In-kind Support
- ☐ Last two years of signed Income Tax returns including schedule attachments (copies)
- ☐ Approval or Denial letter from Medi-Cal
- ☐ Last 2 months of complete bank statements
- ☐ Proof of High Medical Cost (see below for explanation)
- ☐ Other: _____

If the balance represents your liability after insurance, you must provide proof of High Medical Cost. High Medical Cost consist of all medical liabilities that you have paid which equal 10% of your annual household income. Proof of medical cost should be in the form of receipts received or made within the last 12-month period.

If you should have any questions or concerns, please do not hesitate to contact our Patient Business Services Office at (310) 825-8021 Monday through Friday from 7:30 am to 4:30 p.m.

Please mail or bring documents to: Patient Business Services
10920 Wilshire Blvd., Suite 1600
Los Angeles, Ca 90024

Please note: UCLA Health reserves the right to verify all information supplied via a credit and/or property check. To ensure delivery to the address listed above, please consider mailing your documents via certified mail.

PATIENT FINANCIAL INFORMATION FORM
UCLA HEALTH - PATIENT BUSINESS SERVICES

Please complete this worksheet and return to the UCLA Health Patient Business Service office as soon as possible in order for us to determine if you qualify for financial assistance.

Patient Name: _____ Account# _____

Your name(s) and address (including country):

Phone Numbers (circle best daytime number)

Home: Your work:
Your spouse's work:

Social Security Numbers Yours: Your spouse's/Guarantor:

Date(s) of Birth Yours: Your spouse's/Guarantor:

_____
Your employer or business (name and address)/Your spouse's employer or business (name and address):

_____
Age and relationship of people who live with you (dependents only):

_____
Bank Accounts (include Savings, Credit Unions, Individual Retirement Accounts, etc.):

Name of Institution	Address	Type of Account	Account #	Balance
a)				
b)				

_____
Real Estate:

Address (including country)	Current Value	Loan Balance	Date loan will be paid off
a)			
b)			

_____
Motor Vehicles:

Year and Make, License #	Current Value	Loan Balance	Date loan will be paid off
a)			
b)			

_____
Other things you own or are currently buying (stocks, bonds, boats, etc.):

Description	Current Value	Loan Balance	Date loan will be paid off

PATIENT FINANCIAL INFORMATION FORM
UCLA HEALTH - PATIENT BUSINESS SERVICES

MONTHLY INCOME

*Your net pay (attach two recent pay stubs) $_____

*Your spouse's net pay (attach two recent pay stubs) $_____

Rents paid to you $_____

Pensions $_____

Social Security $_____

Profit from your business $_____

Commissions $_____

Other income (source :_____) $_____

TOTAL INCOME $_____

MONTHLY EXPENSES

(Expenses must be reasonable for the size family, location and unique circumstances)

Rent $_____

Mortgage $_____

Alimony/Child Support $_____

Groceries $_____

Utilities

- a) Electricity $_____
- b) Heating oil/Natural gas $_____
- c) Water $_____
- d) Telephone $_____

Transportation (car, bus, taxi) $_____

Medical (not paid by insurance) $_____

Insurance

- a) Auto $_____
- b) Health $_____
- c) Life $_____
- d) Homeowners/Renters $_____

Estimated tax payments $_____

PATIENT FINANCIAL INFORMATION FORM
UCLA HEALTH - PATIENT BUSINESS SERVICES

Auto Loans/Name of Financial Company, bank, etc.

1. _____

2. _____

3. _____

Installment Payments/Name of store, Bank, Credit Card, dates of final payment Amount of payment

1. _____ $_____

2. _____ $_____

3. _____ $_____

OTHER (explain)

$_____

_____

TOTAL MONTHLY EXPENSES $_____

TOTAL INSTALLMENT PAYMENTS $_____

Any Additional Information (expected changes in income, health, etc.)

_____

_____

_____

_____

I hereby authorize UCLA Health to inquire into my credit history through a credit reporting agency to verify the information I have provided.

Signature _____ Date _____

Spouse/Guarantor _____ Date _____