UCLA Health®

Financial Assistance Application

Thank you for choosing UCLA Health as your healthcare provider. In order to determine if you qualify for financial assistance, please return the completed application and supporting documents to:

UCLA Health
Patient Business Services
10920 Wilshire Blvd., Suite 1600
Los Angeles, CA 90024

Business hours: 7:30 a.m. – 4:00 p.m.
Business days: Monday – Friday
Phone number: (310) 825-8021

This is the UCLA Health's application for financial assistance. If you have any questions, the contact information is above.

To be considered, please complete this application to help determine whether you may qualify to receive Charity Care (free care) or a Discounted Payment (reduced, but not free care). Even if you apply, we cannot guarantee that you will qualify. A written response will be provided to all applicants supporting approval/denial after the receipt and review of your completed application and supporting documentation.

The policy covers medically necessary care provided at UCLA Health. Patients scheduled as elective inpatients, non-emergent outpatients, or for follow-up care following discharge require prior approval for financial assistance by the Revenue Cycle Director or their designee. Only medically necessary procedures are eligible for approval.

You may submit the completed, signed and dated application by mail or in person at above location.

- A completed application must include the date and signature of applicant.
- There are no required deadlines for applying.
- Provide proof of income documentation for both you and any co-applicant(s):
    - Most recent pay stubs (previous two months) or
    - Federal tax return (prior year) or
    - Current year W-2 or 1099 earnings statement(s) or
    - Current Social Security Allotment letter or proof of other income

Bank statements are not an acceptable proof of income. Missing documents may cause a delay or denial of financial assistance. You are financially responsible for the outstanding balance until your application is reviewed and approved.

Financial assistance is available to those with or without health insurance. Please note that to qualify for assistance, patients with healthcare coverage must meet income requirements and have out-of-pocket medical expenses in the preceding twelve months that exceed ten percent (10%) of income. Expenses incurred outside of UCLA Health will require receipts in order to be considered in the application.

Please Note: If you are uninsured and meet specific Medi-Cal presumptive eligibility criteria, you are not required to complete this application.

Patient Information

Patient Name	Account Number	Date of Birth
Address	City	State, ZIP Code
Home Phone	Cell Phone	E-Mail
Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic partner	Employment Status ☐ Employed ☐ Self-employed ☐ Retired ☐ Disabled ☐ Unemployed: Last date worked: _____	
Employer Name	Employer Phone Number	
Employer Address	City	State, ZIP Code

Spouse/Domestic Partner/Parent/Guarantor Information

Relationship to Patient ☐ Spouse ☐ Domestic partner ☐ Parent ☐ Guarantor ☐ Other: _____	Employment Status ☐ Employed ☐ Self-employed ☐ Retired ☐ Disabled ☐ Unemployed (Last date worked:_____)
Name	Date of Birth
Employer Name	Employer Phone Number
Employer Address	City
State	ZIP Code

Insurance Coverage

Are you eligible for any health insurance coverage? ☐ Yes ☐ No	Policyholder: _____ Policy Number: _____ Insurer: _____
Have you applied for Medi-Cal? ☐ Yes ☐ No	If "Yes", what is the result of that application?
Have you been screened for Medi-Cal eligibility? ☐ Yes ☐ No	If "Yes", what is the result of that screening?

Income Information

Monthly Gross Income (Current)	Patient/Guarantor	Spouse/Domestic Partner	Total
Employment / Self-Employment Income	$	$	$
Social Security Income	$	$	$
Disability Income	$	$	$
Unemployment Income	$	$	$
Other Income (please specify)	$	$	$
Total Monthly Income (Add Lines Above)	$	$	$

Outstanding Medical Debt at UCLA Health	$	$	$
Other outstanding medical debt	$	$	$

☐ Yes, I consent to the use of presumptive eligibility for the consideration of Charity Care or Discount Payment

I certify that the information in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified by UCLA Health and I authorize them to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provided incorrect information or if the application contains a material error or omission, I will no longer be eligible for financial assistance. If financial assistance was previously granted to me, it may be reversed at that time, and I will be held responsible for the outstanding balance.

_____ _____

Signature of person applying for financial assistance Date

_____ _____

Signature of spouse/domestic partner/guarantor (if applicable) Date