UCLA Health®

# Financial Assistance Application

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

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

Business Hours: 7:30 a.m. to 4:00 p.m.
Business Days: Monday through Friday
Phone Number: (310) 825-8021
MyChart Submission is available, please call to inquire.

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

To be considered, please complete this application to help the organization 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 we receive and review 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, by MyChart, or in person at the above location.

- A completed application must include the date and signature of applicant.
- Provide proof of income documentation for both you and any co-applicant(s):
    - o Recent pay stubs (within 6 months of the first billing) or
    - o Recent Federal tax return (within 12 months before the first billing) or
    - o Recent W-2 or 1099 earnings statement(s) or
    - o Recent Social Security Allotment letter or
    - o Proof of other recent income

Bank statements are not an acceptable proof of income. Missing documents may cause a delay of the review for 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 to be considered in the application.

## Patient Information

| Patient Name | Account Number | Date of Birth |
|---|---|---|
| Address | City | State, Zip Code |
| E-mail | Home Phone | Cell Phone |

Marital Status

☐ Married ☐ Single ☐ Separated

☐ Divorced ☐ Widowed ☐ Domestic partner

Employment Status

☐ Employed ☐ Self-employed ☐ Retired ☐ Disabled

☐ Unemployed, Last date worked:

| Family Size (# of members in your family including you) | |
|---|---|

| Employer Name: | Employer Phone# |
|---|---|
| Employer Address: | Employer City: |
| Employer State: | Employer Zip Code: |

## Spouse/Domestic Partner/Parent/guarantor Information

| Relationship to Patient<br>☐ Spouse ☐ Domestic partner ☐ Parent<br>☐ Guarantor ☐ Other: | Employment Status<br>☐ Employed ☐ Self-employed ☐ Retired<br>☐ Disabled<br>☐ 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?<br>☐ Yes ☐ No | Policyholder: _____<br>Policy Number: _____<br>Insurer: _____ |
| Have you applied for Medi-Cal?<br>☐ Yes ☐ No | If "Yes", what is the result of that application? |
| Have you been screened for Medi-Cal eligibility?<br>☐ Yes ☐ No | If "Yes", what is the result of that application? |

## 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)** | $ | $ | $ |

## High Medical Cost Information

| Type of Medical Debt: | **Patient/Guarantor** | **Spouse/Domestic Partner** | **Total** |
|---|---|---|---|
| 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