UCLA Medical Group
PO Box 240005
Village Station
Los Angeles, CA 90024

Dear Patient,

Thank you for choosing UCLA Health System as your healthcare provider.

This financial hardship application is for physicians' services provided by your physician(s) only, and is not intended for the facility fees on your hospital bills. The following items do not qualify for financial hardship considerations:

- ◻ Cosmetic Services
- ◻ Cash Case Rates (services with pre-arranged cash payments)
- ◻ Third Party Liability

In order to determine if you qualify for financial hardship consideration, please send the required paperwork to our office. You are financially responsible for the outstanding balances until a decision is made on your application:

Documents required:

- Completed Personal Financial Worksheet (attached below)
- Last two paycheck stubs
- Proof of child support or alimony income/payments (if applicable)
- Proof of disability or unemployment income (if applicable)
- Notarized statement of in-kind support (if applicable)
- Copy of last year's signed income tax return
- Medi-Cal denial letter (only if you do not have insurance)
- Two recent bank statements
- Proof of high medical cost (see below for explanation)
  - If your current balance represents your liability after insurance, you must provide proof of High Medical Cost. You will qualify for High Medical Cost if your paid medical liabilities are equal to or greater than 10% of your annual household income. Proof of medical cost should be in the form of receipts received within the last 12-month period.

Please mail documents to address above, Attention: Guarantor Unit Financial Hardship Division.

If you have any questions or need further assistance, we can be reached at 310.301.8860 between 7:00 am **-** 7:00 pm, Monday through Friday, except on holidays. You may fax information to us at 310.301.8878.

Sincerely,

Physicians Billing Office

UCLA Health now offers patients a convenient, secure online bill payment site where you may make a payment, view your statements or review your payment history.
Visit: billing.uclahealth.org

PERSONAL FINANCIAL WORKSHEET
UCLA FACULTY PRACTICE GROUP –PHYSICIANS' BILLING OFFICE

Please note: UCLA Faculty Practice Group reserves the right to verify all information supplied via a credit and/or property check.

Please complete this worksheet and return within 30 days.

Patient Name:	Account #

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

Phone Numbers (circle best daytime number):

Home:	Work:

Social Security Numbers:

Guarantor/Applicant:	Spouse/Patient:

Date(s) of Birth:

Guarantor/Applicant:	Spouse/Patient:

Guarantor/Applicant employer or business (name and address)	Spouse/Patient employer or business (name and address)

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

Name	Age	Relationship

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

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

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 Assets (stocks, bonds, boats, etc.):

Description:	Current Value:	Loan Balance:	Date Loan Will Be Paid Off:
a)			
b)			

MONTHLY INCOME

*Applicant net pay (attach two recent pay stubs)	$
*Spouse net pay (attach two recent pay stubs)	$
Rents paid to you	$
Pensions	$
Social Security	$
Profit from your business	$
Commissions	$
Other income	$
TOTAL INCOME	$
MONTHLY EXPENSES	

(Expenses must be reasonable for the family size, 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	$

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

1.
2.
3.

Installment Payments/Name of store, Bank, Credit Card, final payment date and 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 Faculty Practice Group to check my credit history via a credit reporting agency for verification of the information I have provided.

Signature Date

Spouse/Guarantor Signature Date