

**Financial Assistance Application**

*Please contact your insurance provider to inquire about your eligibility for housing benefits before submitting this application. Return this form to the Housing Assistance Coordinator at 900 Tiverton Ave. Los Angeles, CA 90095 or fax it to (310) 794-8134. Incomplete applications will not be considered.*

Patient's Name: \_\_\_\_\_

UCLA Patient ID Number: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_

*Do you have a lodging benefit?  Yes  No*

Guest's Name(s): \_\_\_\_\_

Guest's Address (no P.O. Boxes): \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Mobile Phone #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Social Worker: \_\_\_\_\_

Arrival Date(s): \_\_\_\_\_

Departure Date(s): \_\_\_\_\_

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**Financial Information:** *Please provide the following information about the monthly finances of the patient. Include a copy of your most recent tax return along with your most recent 2 months of bank statements. If the patient does not file taxes, we need a Verification of Non-filing Letter from the IRS along with the most recent 2 months of bank statements.*

Have you already submitted an application to UCLA Health Admissions & Registration?  Yes  No

Gross Income: \$ \_\_\_\_\_

# of Adults: \_\_\_\_\_ # of Children: \_\_\_\_\_

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**Purpose of your visit to UCLA Health:** *The patient must have a visible appointment in the UCLA Health Patient Scheduling System in order for assistance to be given.*

Doctor's Name \_\_\_\_\_

Doctor's Phone Number \_\_\_\_\_ Appointment Dates: \_\_\_\_\_

Would you like to tell us anything else about your situation that was not mentioned on this application?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_