AB

Patient Business Services HA-11
10920 Wilshire Blvd., Suite 1600
Los Angeles, CA 90024–6502
Fax 310–794–8464

January 22, 2008

pt or guarantor
address
city state, zip

PATIENT'S NAME: pt's name
ACCOUNT(S): account number
BALANCE DUE: total balance due

Dear recipient:

During our conversation today, you stated that you are unable to make payment, or payment in full, on the account referenced above. To consider a discount or settlement, we must have financial documentation that would substantiate an adjustment.

Please complete the enclosed Personal Financial Worksheet; we will use this information to evaluate the possibility of a discount or settlement. Please return the form, completed and signed, and a copy of your last two years' Income Tax returns to my attention by 10 days from today's date.

Thank you for your immediate attention to this matter.

your name
Collections Department
(310) your phone #

PERSONAL FINANCIAL WORKSHEET
UCLA MEDICAL CENTER PATIENT BUSINESS SERVICES

Please complete this worksheet and return to the UCLA Medical Center Patient Business Services office as soon as possible in order for us to determine if you qualify for financial assistance. We are sincere in our efforts to assist you in a timely manner while maintaining strict confidentiality.

Please include your last two years Federal and State Tax Returns and two current copies of banking statements.

Thank you for your cooperation.

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 and Loans, Credit Unions, Certificates of Deposit, Individual Retirement Accounts, etc.):

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

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Credit Cards, checking overdraft protection, line of credit, etc.:

	Name of credit card, bank, etc.	Minimum mo. payment	Credit Limit	Amount Owed
a)				
b)				
c)				
d)				

Life Insurance:

	Name of Company	Policy Holder	Amount you can borrow on the policy
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)				
c)				

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

	Description	Current Value	Loan Balance	Date loan will be paid off
a)				
b)				

PERSONAL FINANCIAL WORKSHEET
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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 $____________________

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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)
$______________

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TOTAL MONTHLY EXPENSES
$______________

TOTAL INSTALLMENT PAYMENTS $______________

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

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

Signature ______________________ Date __________

Spouse/Guarantor ______________________ Date __________