KLAMATH BASIN BEHAVIORAL HEALTH

GROWTH • WELLNESS • COMMUNITY KBBH

2210 N Eldorado Avenue – Klamath Falls, OR 97601 – (541) 883-1030

Financial Assistance Application

Client Last Name:_____ Client First Name:_____ M.I.:_____

Client Date of Birth:_____ Client Social Security Number: _____-_____-_____

Client Marital Status: □ Never Married □ Married □ Divorced □ Widowed

Person responsible for paying the bill and relationship: _____

Address:_____ City:_____Zip Code:_____

Phone Number:_____Cell Phone:_____

Total number in household:_____Number of dependents:_____

Names of people employed, full-time or part-time in household	Relationship	Social Security Number
1. _____	_____	_____-_____-_____
2. _____	_____	_____-_____-_____
3. _____	_____	_____-_____-_____

Proof of all household income and copy of most recent tax return is required.

Please attached verification of all types of income.

Financial assistance will not be applied to your account until proof of income has been received.

Source of income:

$_____ Last 30 day (year to date) pay stubs	$_____ Unemployment	$_____ Social Security/Pension/Veteran
$_____ Stocks, Bonds, IRAs and Investments	$_____ Government Assistance/Disability	$_____ Other

Annual gross household income $_____

Number of household member's _____

Updated 7/15/2016

Maximum Annual Household Income Levels	A	B	C	D	E	F	G
	250%	275%	300%	325%	350%	375%	400%
1	$29,700	$32,670	$35,640	$38,610	$41,580	$44,550	$47,520
2	$40,050	$44,055	$48,060	$52,065	$56,070	$60,075	$64,080
3	$50,400	$55,440	$60,480	$65,520	$70,560	$75,600	$80,640
4	$60,750	$66,825	$72,900	$78,975	$85,050	$91,125	$97,200
5	$71,100	$78,210	$85,320	$92,430	$99,540	$106,650	$113,760
6	$81,450	$89,595	$97,740	$105,885	$114,030	$122,175	$130,320
7	$91,825	$101,008	$110,190	$119,373	$128,555	$137,738	$146,920
8	$102,225	$112,448	$122,670	$132,893	$143,115	$153,338	$163,560

If you fall in category **A** our agency will cover the cost of medically necessary services. If you fall in categories **B, C, D, E, F** or **G** you are responsible for the co-payment and then our agency will cover the cost of medically necessary services after all other payers have been billed and processed.

Fee Schedule	A	B	C	D	E	F	G
Co-pay for services	$0.00	$5.00	$10.00	$15.00	$20.00	$25.00	$30.00

Client responsibility per services $_____

Co-pay fees will be due before seeing a provider (balance to be billed).

Your co-pay is a portion of your bill. The balance will be billed to your insurance and/or covered by the contracted payer.

The application is true to the best of my knowledge. If KBBH seeks verification of the information, I authorize any party contacted by KBBH to release the requested verification to KBBH.

Applicant's Signature:_____ Date:_____

For Office Use Only

Family size:_____Total household income:_____p/year, month, week (x 4.33)

Proof of income provided:_____

Co-pay based on schedule: $_____

Approved by:_____

Expiration date:_____