

### Apply for Financial Assistance

Klamath Basin Behavioral Health provides necessary services to individuals seeking treatment, regardless of their ability to pay. Financial assistance is available for those with no insurance coverage or who need assistance with their portion of the cost. If you need financial assistance, please complete this form to the best of your ability. You may contact Client Financial Services at 541-883-1030 with any questions. Completed forms can be faxed to 541-205-5043, emailed to [billing@kbbh.org](mailto:billing@kbbh.org), mailed to 2210 N Eldorado Ave, Klamath Falls, Oregon 97601, or returned to our front office.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Client ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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. _____	_____	_____ - _____ - _____

Primary Insurance Carrier: \_\_\_\_\_ ID No: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_ ID No: \_\_\_\_\_

***Please note that proof of all household income and a copy of most recent tax returns are required. Please attach verification of all types of income. Financial assistance will not be applied to your account until proof of income has been received.***

**Income Sources:**

\$ _____ 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 members: \_\_\_\_\_

**Federal Poverty Table, Updated 1/21/20**

Size of Household	Maximum Household Income Levels							
	A	B	C	D	E	F	G	H
*								
1	\$12,760	\$31,900	\$35,090	\$38,280	\$41,470	\$44,660	\$47,850	\$51,040
2	\$17,240	\$43,100	\$47,410	\$51,720	\$56,030	\$60,340	\$64,650	\$68,960
3	\$21,720	\$54,300	\$59,730	\$65,160	\$70,590	\$76,020	\$81,450	\$86,880
4	\$26,200	\$65,500	\$72,050	\$78,600	\$85,150	\$91,700	\$98,250	\$104,800
5	\$30,680	\$76,700	\$84,370	\$92,040	\$99,710	\$107,380	\$115,050	\$122,720
6	\$35,160	\$87,900	\$96,690	\$105,480	\$114,270	\$123,060	\$131,850	\$140,640
7	\$39,640	\$99,100	\$109,010	\$118,920	\$128,830	\$138,740	\$148,650	\$158,560
8	\$44,120	\$110,300	\$121,330	\$132,360	\$143,390	\$154,420	\$165,450	\$176,480
9	\$48,600	\$121,500	\$133,650	\$145,800	\$157,950	\$170,100	\$182,250	\$194,400
10	\$53,080	\$132,700	\$145,970	\$159,240	\$172,510	\$185,780	\$199,050	\$212,320

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

**Co-Pay Fee Schedule**

	A	B	C	D	E	F	G	H
% of Federal Poverty Level	100%	250%	250%-275%	275%-300%	300%-325%	325%-350%	350%-375%	375%-400%
Co-Pay	<b>\$0.0</b>	<b>\$0.0</b>	<b>\$5.00</b>	<b>\$10.00</b>	<b>\$15.00</b>	<b>\$20.00</b>	<b>\$25.00</b>	<b>\$30.00</b>

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: \_\_\_\_\_