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 attach 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 11/06/2017

Maximum Annual Household Income Levels	A	B	C	D	E	F	G
	0-250%	**275%**	**300%**	**325%**	**350%**	**375%**	**400%**
1	$30,150	$33,165	$36,180	$39,195	$42,210	$45,225	$48,240
2	$40,600	$44,660	$48,720	$52,780	$56,840	$60,900	$64,960
3	$51,050	$56,155	$61,260	$66,365	$71,4700	$76,575	$81,680
4	$61,500	$67,650	$73,800	$79,950	$86,100	$92,250	$98,400
5	$71,950	$79,145	$86,340	$93,535	$100,730	$107,925	$115,120
6	$82,400	$90,640	$98,880	$107,120	$115,360	$123,600	$131,840
7	$92,850	$102,135	$111,420	$120,705	$129,990	$139,275	$148,560
8	$103,300	$113,630	$123,960	$134,290	$144,620	$154,950	$165,280

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:____