

Bastyr Center for Natural Health
Annual Income Assistance Rates Based on Federal Poverty
Guidelines
Effective 2020

If your income falls at or below the Income Level for your household size and you provide appropriate documentation, you may qualify for our Income Based Adjustment.

Household size		Income Level
1	per year	\$31,900
	per month	\$2,658
2	per year	\$43,100
	per month	\$3,592
3	per year	\$54,300
	per month	\$4,525
4	per year	\$65,500
	per month	\$5,458
5	per year	\$76,700
	per month	\$6,392
6	per year	\$87,900
	per month	\$7,325
7	per year	\$99,100
	per month	\$8,258
8	per year	\$110,300
	per month	\$9,192

BASTYR CENTER FOR NATURAL HEALTH
3670 STONE WAY N
SEATTLE, WA 98103
(206) 834-4100

INCOME BASED ADJUSTMENT APPLICATION

Welcome to the Bastyr Center for Natural Health. We have established a reduced rate for services in response to the needs of those patients whose financial status makes it difficult to afford our regular fees. ***Please note that those who qualify for the reduced rate will receive a discount on the cost of the visit only, and will not receive discounts on any fees such as lab work, dispensary items, or supplies. This assistance for our patients is available only when payment is made at the time of service.***

Income based adjustment rates are determined by Federal Poverty Guidelines for our patients who will not be billing insurance.

Patient Services Staff will be responsible for determining eligibility based on documents you provide. You will be required to submit **2** supporting documents as proof of your household income and ***you must re-qualify for the reduced rate on an annual basis.***

We will accept **2 of the following documents** for verification:

- 2 consecutive pay stubs, or your most recent pay stub which shows year to date cumulative figures for at least 2 months.
- An award letter from a government agency which confirms your financial status, i.e. SSI, Disability, or Unemployment Insurance determination.
- 2 month bank statement which shows your deposits.
- Provider One Card, TANF Letter (DSHS letter)
- Tax forms.

FAMILY SIZE: ___ GROSS FAMILY INCOME: \$ _____ PER _____ (mo/yr)

I certify this information to be true and an accurate account of my income and family size.

Printed Patient Name

Date

Signature of Patient /Guardian

Area Code/ Phone Number

Street Address Apt.

City State ZIP

FOR OFFICE USE ONLY

DOCUMENTATION VERIFICATION: _____

TYPE _____ PSR: _____ DATE: _____ RENEW: _____ (1 year)