Bastyr University Clinic

Annual Income Assistance Rates Based on Federal Poverty Guidelines
Effective 2025

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	$23,475
	per month	$1,956
2	per year	$31,725
	per month	$2,644
3	per year	$39,975
	per month	$3,331
4	per year	$48,225
	per month	$4,019
5	per year	$56,475
	per month	$4,706
6	per year	$64,725
	per month	$5,394
7	per year	$72,975
	per month	$6,081
8	per year	$81,225
	per month	$6,769

BASTYR UNIVERSITY CLINIC
4110 SORRENTO VALLEY BLVD
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(858) 246-9730

INCOME BASED ADJUSTMENT APPLICATION

Welcome to the Bastyr University Clinic. 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** different types of 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" forms 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)