

**Bastyr University Clinic**  
**Annual Income Assistance Rates Based on Federal Poverty**  
**Guidelines**  
**Effective 2026**

**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	\$23,940
	per month	\$1,995
2	per year	\$32,460
	per month	\$2,705
3	per year	\$40,980
	per month	\$3,415
4	per year	\$49,500
	per month	\$4,125
5	per year	\$58,020
	per month	\$4,835
6	per year	\$66,540
	per month	\$5,545
7	per year	\$75,060
	per month	\$6,255
8	per year	\$83,580
	per month	\$6,965

**BASTYR UNIVERSITY CLINIC  
4110 SORRENTO VALLEY BLVD  
SAN DIEGO, CA 92121  
(858) 246-9730**

**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** 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)