

**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 an assistance program 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 assistance with the cost of the visit only, and will not receive discounts on any fees for 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 fee rates are available at two levels for our patients. Persons whose earnings fall below 150% or 250% of the federal poverty guidelines and ***do not have insurance, or whose insurance plan does not offer natural medicine benefits*** are eligible with supporting documentation.

Patient Services Staff is responsible for determining eligibility based on 2 documents provided. 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 a semi-annual basis.*** We will accept **2 of the following documents** for verification:

- 3 consecutive pay stubs, or your most recent pay stub which shows year to date cumulative figures for at least 3 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.
- Tax forms.

If you do not have access to 2 of the above bulleted documents, the following agencies can provide proof of income at no cost to you:

- The Department of Employment Security/ Work Source affiliates
- The Social Security Administration

If you cannot provide this information, contact the Patient Services Manager for application review.

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, I further certify that I do not have insurance or my insurance plan will not cover natural medicine claims.

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: _____ (6 months)