Apply for Financial Assistance

Klamath Basin Behavioral Health provides necessary services to individuals seeking treatment, regardless of their ability to pay. Financial assistance is available for those with no insurance coverage or who need assistance with their portion of the cost. If you need financial assistance, please complete this form to the best of your ability. You may contact Client Financial Services at 541-883-1030 with any questions. Completed forms can be faxed to 541-205-5043, emailed to billing@kbbh.org, mailed to 2210 N Eldorado Ave, Klamath Falls, Oregon 97601, or returned to our front office.

Last Name:_____ First Name:_____ M.I.:_____

Client ID: _____ Date of Birth:_____ Social Security Number: ____-____-____

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. _____	_____	____-____-____

Primary Insurance Carrier: _____ ID No: _____

Secondary Insurance Carrier: _____ ID No: _____

Please note that proof of all household income and a copy of most recent tax returns are 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.

Income Sources:

$_____ 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 members**: _____

Federal Poverty Table, Updated 3/09/25

Size of Household	Maximum Household Income Levels							
*	A	B	C	D	E	F	G	H
1	$15,060	$37,650	$41,415	$45,180	$48,945	$52,710	$56,475	$60,240
2	$20,440	$51,100	$56,210	$61,320	$66,430	$71,540	$76,650	$81,760
3	$25,820	$64,550	$71,005	$77,460	$83,915	$90,370	$96,825	$103,280
4	$31,200	$78,000	$85,800	$93,600	$101,400	$109,200	$117,000	$124,800
5	$36,580	$91,450	$100,595	$109,740	$118,885	$128,030	$137,175	$146,320
6	$41,960	$104,900	$115,390	$125,880	$136,370	$146,860	$157,350	$167,840
7	$47,340	$118,350	$130,185	$142,020	$153,855	$165,690	$177,525	$189,360
8	$52,720	$131,800	$144,980	$158,160	$171,340	$184,520	$197,700	$210,880
9	$58,100	$145,250	$159,775	$174,300	$188,825	$203,350	$217,875	$232,400
10	$63,480	$158,700	$174,570	$190,440	$206,310	$222,180	$238,050	$253,920

If you fall in category **A or B our agency will cover the cost of medically necessary services. If you fall in categories **C, D, E, F, G, or H** you are responsible for the co-payment below and then our agency will cover the cost of medically necessary services after all other payers have been billed and processed.*

Co-Pay Fee Schedule

	A	B	C	D	E	F	G	H
% of Federal Poverty Level	100%	250%	250%-275%	275%-300%	300%-325%	325%-350%	350%-375%	375%-400%
Co-Pay	**$0.0**	**$0.0**	**$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: _____