Sliding Fee Scale Application

It is the policy of High Country Behavioral Health to provide essential services regardless of the client's ability to pay. A sliding fee scale is offered based on number of household members and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible.

The sliding fee scale only applies to individual, family, and/or group therapy services, and mental health medication management services. It does not apply towards primary care, transcranial magnetic stimulation therapy, and other such services. It does not apply towards services or equipment that are purchased from outside, including reference laboratory testing, prescriptions, other such services. This form must be completed every 12 months or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD		**PLACE OF EMPLOYMENT**		
STREET	**CITY**	**STATE**	**ZIP**	**PHONE**

WHO LIVES IN YOUR HOUSE?
PLEASE LIST SPOUSE, SECONDARY GUARDIAN, AND DEPENDENTS UNDER AGE 18.

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
SELF (Client)		DEPENDENT	
Guardian (If applicable)		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

ANNUAL HOUSEHOLD INCOME

SOURCE	SELF	SPOUSE	GUARDIAN	OTHER	TOTAL
Gross wages, salaries, tips, etc.					
Income from business, self-employment, and dependents					
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income					
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources					
Total Income					

NOTE: Copies of tax returns, pay stubs (3), or other information verifying income are required before a sliding fee is approved.

I CERTIFY THAT THE HOUSEHOLD MEMBERS AND INCOME SHOWN ABOVE ARE CORRECT.

NAME (PRINT)_____ **DATE** _____

SIGNATURE _____

Office Use Only

Date Received: _____

Patient Name: _____

Approved Amount:_____Date Approved: _____

Approved by: _____

Verification Checklist	Yes	No
Identification/Address: Driver's License, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		

Sliding Fee Schedule

Effective 07/2023

All fees subject to change at any time without prior written notice. Please note that income is calculated based on the federal poverty guidelines, and household total income is reduced by the number of individuals living in the home.

Annual Gross Income	Indiv/Family/Case Mgmt	Group Therapy	Substance Group	Med Management (1/2 hour)
<$14,580	$5.00	$2.50	$2.50	$10.00
$14,580 - $19,720	$8.00	$4.00	$4.00	$16.00
$19,720 - $24,860	$12.00	$6.00	$6.00	$24.00
$24,860-$30,000	$15.00	$7.50	$7.50	$30.00
$30,000-$35,140	$25.00	$12.50	$12.50	$50.00
$35,140- $40,280	$35.00	$17.50	$17.50	$70.00
$40,280 - $45,420	$45.00	$22.50	$22.50	$90.00
$45,420-$50,560	$55.00	$27.50	$27.50	$110.00
$50,560- $55,700	$65.00	$32.50	$32.50	$130.00
$55,700- $60,840	$75.00	$37.50	$37.50	$150.00
$60,840 - $65,980	$85.00	$42.50	$42.50	$170.00
$65,980- $71,120	$100.00	$50.00	$50.00	$200.00
$71,120 - $76,260	$120.00	$50.00	$50.00	$200.00
$76,260 - $81,400	$140.00	$50.00	$50.00	$200.00
$81,400- $86,540	$160.00	$50.00	$50.00	$200.00
$86,540- $91,680	$250.00	$50.00	$50.00	$200.00
>$91,680	$250.00	$50.00	$50.00	$200.00

Rate for Groups: $_____ Individual/Case Management/Couples/Family Services: $ _____ Med Management: $ _____

The fee scale above indicates what will be charged for services. High Country Behavioral Health does not discriminate in the provision of services to individuals based on their inability to pay, race, color, sex, national origin, disability, religion, or sexual orientation. No one will be denied access to services due to inability to pay or method of payment. However, services may be denied to clients who refuse to pay according to an agreed upon payment plan. The maximum rate in each category will be charged until proof of HOUSEHOLD INCOME is received and a new fee is agreed upon. Household income will be verified by our business office through the past month's pay stubs (attached to this form). **PAYMENT IS DUE AT TIME OF SERVICE.**

_____ _____ _____ _____

Client Signature Date Revenue Cycle Specialist Date

Client Printed Name: _____ Client ID Number: _____