Sliding Fee Discount Application

It is the policy of High Country Behavioral Health to provide essential services regardless of theclient's ability to pay. Discounts are offered based on family size 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 for a discount.

This discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, andtranscranial magnetic stimulation therapy, and 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	
DEPENDENT		DEPENDENT	
OTHER		OTHER	

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, 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 pay stubs (3), or other information verifying income will berequired before a discount is approved.

I CERTIFY THAT THE FAMILY SIZE AND INCOME SHOWN ABOVE ARE CORRECT.

NAME (PRINT)____ **DATE** ________________

SIGNATURE ____

Office Use Only

Date Received: _________________

Client Name: ____

Approved Discount:____________________________Date Approved: _______________________

Approved by: ____

Verification Checklist	Yes	No
Identification/Address: Driver's License, utility bill, employment ID, or other		
Income: (3) most recent pay stubs, or other		
Insurance: Insurance Cards		

Sliding Fee Schedule

Effective 05/2022

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
<$13,590	$3.00	$3.00	$3.00	$5.00
$13,590 - $18,310	$6.00	$6.00	$6.00	$10.00
$18,311 - $23,031	$9.00	$9.00	$9.00	$20.00
$23,032 - $27,752	$10.00	$12.00	$12.00	$30.00
$27,753 - $31,040	$20.00	$15.00	$15.00	$40.00
$31,041 - $35,580	$30.00	$18.00	$18.00	$50.00
$35,581 - $40,571	$40.00	$21.00	$21.00	$60.00
$40,572 - $45,292	$50.00	$24.00	$24.00	$70.00
$45,293 - $54,461	$60.00	$27.00	$27.00	$80.00
$54,462 - $59,182	$70.00	$30.00	$30.00	$90.00
$59,183 - $63.903	$80.00	$33.00	$33.00	$100.00
$63,904 - $68,624	$90.00	$35.00	$35.00	$110.00
$68,265 - $78,064	$100.00	$40.00	$40.00	$130.00
$78,065 - $86,785	$110.00	$45.00	$45.00	$160.00
$86,786 - $91,505	$120.00	$50.00	$50.00	$165.00
>$91,505	$189.00	$60.00	$60.00	$215.00

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

The fee scale above indicates that 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 receive and a new fee is agreed upon. Household income will be verified by our office through the past month's (3) pay stubs (attached to this form).

______________________________ ____________ ______________________________ ____________

Client Signature Date Revenue Cycle Specialist Date

Client Printed Name: ______________________________

Client ID Number: ______________________________