HIGH COUNTRY BEHAVIORAL HEALTH
A New Way of Thinking

Sliding Fee Discount Application

It is the policy of High Country Behavioral Health to provide essential services regardless of the client's ability to pay. High Country Behavioral Health offers discounts 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 behavioral health services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist and transcranial 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**

PLEASE LIST SPOUSE AND DEPENDENTS UNDER AGE 18.

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
SELF		OTHER	
OTHER		OTHER	
OTHER		OTHER	
OTHER		OTHER	

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ANNUAL HOUSEHOLD INCOME

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Income from business, self-employment				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, , veterans'payments, survivor benefits, pension or retirement income				
Alimony, child support, and other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

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

NAME (PRINT)_____ **DATE** _____

_____

SIGNATURE _____

Office Use Only

Patient Name: _____

Approved Discount:_____

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		

Self-declaration of income may also be used

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: _____