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. 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, 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		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

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ANNUAL HOUSEHOLD INCOME

SOURCE	SELF	SPOUSE	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, 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		
Insurance: Insurance Cards		

2020-2021 HIGH COUNTRY BEHAVIORAL HEALTH SLIDING FEE SCALE

When a client does not have insurance we use the following steps to calculate hourly rates for group, individual and psychiatric services.

Step 1: Collect the past two months pay stubs and previous year's tax return (page one of the 1040) and attach to this form.
Step 2: Deduct $373 per dependent from monthly gross income (or $4480 for annual income) prior to computing fee.
Step 3: Circle the monthly or annual gross income after making the appropriate deductions per dependent.
Step 4: Circle the hourly rate for Individual/Family/Case Management/Individual Rehab Services/Psychiatric services on the table.

Annual Gross Income	% Poverty	Individual/Family Case Mngt/Assessment per Hour	Group 6+ Hours/week	Group <6 Hours/week	Individual Rehab Services per Hour	Psychiatric Services (per 1/2 hour sessions)
<$6,001-$12,760	100%	$0.00	$0.00	$0.00	$0.00	$0.00
$12,761-$17,240	150%	$2.00	$1.00	$1.00	$1.00	$2.00
$17,241-$21,720	200%	$5.00	$2.50	$2.00	$2.50	$5.00
$21,721-$26,200	250%	$10.00	$3.75	$7.50	$3.75	$10.00
$26,201-$30,680	300%	$15.00	$5.00	$10.00	$5.00	$15.00
$30,681-$35,160	350%	$20.00	$6.25	$12.50	$6.25	$20.00
$35,161-$39,640	400%	$25.00	$7.50	$15.00	$7.50	$25.00
$39,641-$44,120	450%	$30.00	$8.75	$17.50	$8.75	$30.00
$44,121-$48,600	500%	$35.00	$10.00	$20.00	$10.00	$35.00
$48,601-$53,080	550%	$40.00	$11.25	$22.50	$11.25	$40.00
$53,081-$57,560	600%	$45.00	$12.50	$25.00	$12.50	$45.00
$57,561-$62,040	650%	$50.00	$15.00	$30.00	$15.00	$50.00
$62,041-$66,520	700%	$60.00	$17.50	$35.00	$17.50	$60.00
$65,521-$71,000	750%	$70.00	$20.00	$40.00	$20.00	$70.00
$71,001-$75,480	800%	$80.00	$22.50	$45.00	$22.50	$80.00
$75,481-$79,960	850%	$90.00	$25.00	$50.00	$25.00	$90.00
$79,961-$84,440	900%	$100.00	$27.50	$55.00	$27.50	$100.00
$84,441-$88,920	950%	$110.00	$30.00	$60.00	$30.00	$110.00
$88,921+	1000%	$120.00	$32.50	$65.00	$32.50	$120.00

Hourly Rate for Group: $_____

Hourly Rate for Individual/Case Mangement/Couples/Family Services: $_____

(there is a $25 NO SHOW FEE when failing to cancel a service 24+ hours prior to the service.)

(there is a $25 Return Check Fee for any returned checks)

_____ _____

Client Signature Date Therapist Signature Date

The fee scale above indicates the fees 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 catergory 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 and first page of the previous year's tax return (attached to this form.)