

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	

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		



Sliding Fee Schedule

Effective 02/01/2021

All fees subject to change at any time without prior written notice.

Annual Gross Income	Discount %	Poverty %	Indiv/Family/Case Mgmt	Group Therapy	Substance Group	Med Management
<\$12,800	100%	100%	\$0.00	\$0.00	\$0.00	\$0.00
\$12,880 - \$17,420	95%	105%	\$3.00	\$3.00	\$3.00	\$5.00
\$17,421 - \$21,960	90%	110%	\$6.00	\$6.00	\$6.00	\$10.00
\$21,961 - \$26,500	85%	115%	\$9.00	\$9.00	\$9.00	\$20.00
\$26,501 - \$31,040	80%	120%	\$10.00	\$12.00	\$12.00	\$30.00
\$31,041 - \$35,580	75%	125%	\$20.00	\$15.00	\$15.00	\$40.00
\$35,581 - \$40,120	70%	130%	\$30.00	\$18.00	\$18.00	\$50.00
\$40,121 - \$44,660	65%	135%	\$40.00	\$21.00	\$21.00	\$60.00
\$44,661 - \$49,201	60%	140%	\$50.00	\$24.00	\$24.00	\$70.00
\$49,201 - \$53,741	55%	145%	\$60.00	\$27.00	\$27.00	\$80.00
\$53,742 - \$58,281	50%	150%	\$70.00	\$30.00	\$30.00	\$90.00
\$58,282 - \$62,821	45%	155%	\$80.00	\$33.00	\$33.00	\$100.00
\$62,822 - \$67,361	40%	160%	\$90.00	\$35.00	\$35.00	\$110.00
\$67,362 - \$71,901	35%	165%	\$100.00	\$40.00	\$40.00	\$130.00
\$71,902 - \$76,441	30%	170%	\$110.00	\$45.00	\$45.00	\$160.00
\$76,441 - \$80,981	20%	180%	\$120.00	\$50.00	\$50.00	\$180.00
\$80,982 - \$85,521	10%	190%	\$130.00	\$55.00	\$55.00	\$200.00
>\$85,522	0%	>200%	\$189.00	\$60.00	\$60.00	\$220.00

Hourly Rate for Groups: \$ _____

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

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 business office through the past month's pay stubs (attached to this form).

Client Signature

Date

Revenue Cycle Specialist

Date

Client Printed Name

Client ID Number