HIGH COUNTRY BEHAVIORAL HEALTH
A New Way of Thinking

Sliding-Fee-Scale Application

High Country Behavioral Health offers a sliding-fee-scale for individuals who do not have health insurance or for services not covered by insurance. The sliding-fee-scale is offered based on number of household members and annual household income.

The sliding-fee-scale is only used for behavioral health therapy for Individuals, Families, and/or Group Therapy, and Case Management. The sliding-fee-scale does not apply toward Medication Management, Primary Care, Transcranial Magnetic Stimulation (TMS) Therapy, Spravato, Laboratory Testing, Prescriptions, Equipment, or Manuals. You must complete this form every 12 months or if your financial situation changes.

Please complete the following information and return it to the front desk to determine if you or members of your family are eligible.

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

WHO LIVES IN YOUR HOUSE?
PLEASE LIST ALL HOUSEHOLD MEMBERS, INCLUDING THOSE UNDER AGE 18.

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
SELF (Client)		OTHER	
OTHER		OTHER	
OTHER		OTHER	
OTHER		OTHER	

ANNUAL HOUSEHOLD INCOME

SOURCE	SELF	OTHER	OTHER	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, three (3) pay stubs, or other information verifying income are required before a sliding-fee-scale is approved.

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

NAME (PRINT) _____ **DATE** _____

SIGNATURE _____

Office Use Only

PATIENT NAME: _____

APPROVED DISCOUNT: _____

APPROVED BY: _____

DATE APPROVED: _____

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

Sliding Fee Schedule

Effective 02/2026

Poverty Level	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
Family Size	Discount 100%	Discount 90%	Discount 80%	Discount 70%	Discount 60%	Discount 50%	Discount 40%	Discount 30%	Discount 20%	Discount 15%	Discount 10%	Discount 0%
1	$15,960	$17,556	$19,152	$20,748	$22,344	$23,940	$25,536	$27,132	$28,728	$30,324	$31,920	$31,921
2	$21,640	$23,804	$25,968	$28,132	$30,296	$32,460	$34,624	$36,788	$38,952	$41,116	$43,280	$43,281
3	$27,320	$30,052	$32,784	$35,516	$38,248	$40,980	$43,712	$46,444	$49,176	$51,908	$54,640	$54,641
4	$33,000	$36,300	$39,600	$42,900	$46,200	$49,500	$52,800	$56,100	$59,400	$62,700	$66,000	$66,001
5	$38,680	$42,548	$46,416	$50,284	$54,152	$58,020	$61,888	$65,756	$69,624	$73,492	$77,360	$77,361
6	$44,360	$48,796	$53,232	$57,668	$62,104	$66,540	$70,976	$75,412	$79,848	$84,284	$88,720	$88,721
7	$50,040	$55,044	$60,048	$65,052	$70,056	$75,060	$80,064	$85,068	$90,072	$95,076	$100,080	$100,081
8	$55,720	$61,292	$66,864	$72,436	$78,008	$83,580	$89,152	$94,724	$100,296	$105,868	$111,440	$111,441
For each additional person, add	$5,680	$6,248	$6,816	$7,384	$7,952	$8,520	$9,088	$9,656	$10,224	$10,792	$11,360	$11,360

*Based on the 2026 Federal Poverty Guidelines for the 48 contiguous states and the District of Columbia. Please note that there are separate guidelines for Alaska and Hawaii, and that the thresholds would differ for sites in those two states. Sites in Puerto Rico and other outlying jurisdictions would use the above guidelines.

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

The sliding-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. 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 utilizing the past three (3) pay stubs (attached to this form). **PAYMENT IS DUE AT TIME OF SERVICE.**

Client Signature: _____ Date _____

Client Printed Name: _____ Client ID Number: _____

Revenue Cycle Specialist _____ Date _____