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.

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

This application is for a total of 13 visits, regardless of service type. Additional services may be requested after the first 13 visits have been used.

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	

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, 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

Date Received: _____

Patient Name: _____

Approved Amount:_____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 (3) most recent pay stubs, or other		
Insurance: Insurance Cards		

Sliding Fee Schedule

Effective 07/2024

Annual Gross Income	Discount %	Indiv/Family/Case Mngt	Group Therapy
< $15,060	90%	$25.00	$12.50
$15,060 - $20,440	86%	$35.00	$17.50
$20,441 - $25,820	82%	$45.00	$22.50
$25,821-$31,200	78%	$55.00	$27.50
$31,201- $36,580	74%	$65.00	$32.50
$36, 581- $41,960	70%	$75.00	$37.50
$41,961-$47,340	66%	$85.00	$42.50
$47,341-$52,720	62%	$95.00	$47.50
$52,721-$58,100	60%	$100.00	$50.00
$58,101 - $63,480	56%	$110.00	$55.00
$63,481 - $68,860	52%	$120.00	$60.00
$68,861- $74,240	48%	$130.00	$60.00
$74,241- $79,620	44%	$140.00	$60.00
< $79,621	40%	$150.00	$60.00

All fees are 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.

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 Revenue Cycle Specialist Date

Client Printed Name: _____ Client ID Number: _____