High Falls Speech Therapy Center, LLC
8 Silk mill Drive | Suite 204 | Hawley, PA. 18428

Sliding Fee Discount Policy

The mission of High Falls Speech Therapy Center is to make therapy more accessible despite the termination of our enrollment in Pennsylvania Medicaid with an effective date of 10/1/2025. Therefore, all our services will be offered at a discount, using a sliding fee scale. High Falls Speech Therapy Center will base the program eligibility on a person's ability to pay and will not discriminate based on age, gender, race, sexual orientation, creed religion, disability, or national origin.

The Federal Poverty Guidelines (http://aspe.hhs.gov/poverty) are used in creating and annually updating the sliding fee schedule to determine eligibility. The fee you will pay is based on your gross annual income and number of dependents and will be established based on your tax return. It will be reassessed every 12 months.

To use the Sliding Scale Fee Program, you must complete an application. You should apply whether or not you have insurance, because if you qualify for a discount, we will apply it to your co-pay and deductibles.

Sliding Fee Rate

How to find your fee:

1.Determine your household size. This includes a spouse, parent that lives with you, child, and any dependents that you include on your tax return. Your Tax return must be included with your application.
2. Find your total gross household income from your federal tax return. Include all earned income, child support, Disability, and Social Security income. (SNAP, loans, and non-recurring, irregular payments are not included in the household income.)
3. Once you have determined your household income and size, find where they intersect on the table; this identifies your self-pay category.

2025 Annual Income		2025 Family Size: Total number of family members dependent on taxable income including Those that live in the home 50% of the time.							
Lower	Upper	Single	2	3	4	5	6	7	8
$0.00	$15,650	1	1	1	1	1	1	1	1
$15,651	$21,150	2	1	1	1	1	1	1	1
$21,151	$26,650	2	2	1	1	1	1	1	1
$26,651	$32,150	3	2	2	1	1	1	1	1
$32,151	$37,650	3	3	2	2	1	1	1	1
$37,651	$43,150	3	3	3	2	2	1	1	1
$43,151	$48,650	4	3	3	3	2	2	1	1
$48,651	$54,150	4	4	3	3	3	2	2	2
$54,151	$59,650	5	4	4	3	3	3	2	2
$59,651	$65,150	5	5	4	4	3	3	3	2
$65,151	$70,650	5	5	5	4	4	3	3	3

Standard Evaluation Fees

Evaluation Services	Standard Fee
Assessment of Fluency	$300
Assessment of Speech	$300
Assessment of Speech and Language	$425
Assessment of Voice	$300
Assessment of Aphasia	$300
Evaluation of Swallowing	$300
Evaluation for a speech generating device	$300

Evaluation Sliding Fees

Evaluation Services	Tier 5 (100%)	Tier 4 (80%)	Tier 3 (60%)	Tier 2 (40%)	Tier 1 (30%)
Assessment of Fluency	$300	$240	$180	$120	$90
Assessment of Speech	$300	$240	$180	$120	$90
Assessment of Speech and Language	$425	$340	$255	$170	$127.5
Assessment of Voice	$300	$240	$180	$120	$90
Assessment of Aphasia	$300	$240	$180	$120	$90
Evaluation of Swallowing	$300	$240	$180	$120	$90
Evaluation for a speech generating device	$300	$240	$180	$120	$90

Standard Therapy Fees

30-minute private pay rate	$70
45-minute private pay rate	$90
60-minute private pay rate	$130

Therapy Sliding Fees

Duration	Tier 5 (100%)	Tier 4 (80%)	Tier 3 (60%)	Tier 2 (40%)	Tier 1 (30%)
30 minutes	$70	$56	$42	$28	$21
45 minutes	$90	$72	$54	$36	$27
60 minutes	$130	$104	$78	$52	$39

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Sliding Fee Discount Agreement

I, _____(Client/Parent/Guardian name), certify that I do not have health insurance or certify that I cannot utilize health insurance for services rendered by High Falls Speech Therapy Center and/or that due to my current financial situation, I cannot afford the full fee rate of therapy ($70, $90, $130) and evaluation ($300, $425). My total household income is not sufficient to cover the cost of therapy and therefore, I request that my fees be adjusted. Please initial _____

I understand that the fee for services with High Falls Speech Therapy Center will be $_____ for _____ evaluation and $_____ for therapy. Please initial _____

I understand that fees are payable at the time of each session, unless other arrangements are made in advance. Please initial _____

I further understand that I will not be charged for any appointments that I cancel at least 24 hours in advance. Additionally, I understand that appointments I do not cancel at least 24 hours in advance are subject to a $35 dollar cancelation fee. I am solely responsible for these charges as they apply. Please initial _____

I agree to notify High Falls Speech Therapy Center of any substantive changes in my financial situation (such as increase or decrease of my income) within 30 days of the change and understand that the fee may change according to my updated financial situation. Please initial _____

A continuance of Sliding Scale benefits is not guaranteed and is subject to modifications and/or elimination at the sole discretion of High Falls Speech Therapy Center.

_____ _____
Client /Parent/Guardian Printed Name Date

_____ _____
Client/Parent/Guardian Signature Date

_____ _____
Louise Eitelberg, Owner Date