Substance Use Disorder
Request to Reduce or Waive Assessed Fee

Consumer Name: _____ Case #: _____

Assessed Fee: _____% of service cost **Effective Date**:_____

☐ **Request for fee to be reduced to _____% of service cost**

☐ **Request for fee to be waived**

Clinical rationale for reduction or waiver of assessed fee:_____
_____
_____
_____
_____
_____
_____
_____
_____

(Attach more paper if necessary)

_____
Consumer/Responsible Party Signature **Date**

_____
Clinician Signature **Date**

(To be completed by Executive Director of SUD Service Program)

Request to reduce or waive fee:

☐ **Approved**

☐ **Approved with the following modification**: _____

☐ **Denied**

_____
Executive Director Signature **Date**

Cc: Case Record