FEE ADJUSTMENT REQUEST

To be completed when your fee needs to be adjusted due to inability to pay.

Please attach copies of supporting documents, e.g. pay stubs, bills, etc.
Expenses that are not allowed: Cable, Gifts and donations, Cigarettes and alcohol, Deferred compensation, Entertainment, Any expense (with the exception of food) that does not have supporting documents.

The fee adjustment will not take effect until all information has been completed and returned to this office with supporting documents attached.

NAME:_____ DATE:_____

PRIMARY THERAPIST:_____

GROSS MONTHLY INCOME	**AVERAGE MONTHLY EXPENSES**
Self:	Mortgage/Rent/Taxes:
Spouse or Partner:	Insurance:
Other Income:	Utilities/Fuel:
	Food (estimate):
	Medical costs (non-psych):
	Installment Loans:
	Other:
TOTAL MONTHLY INCOME:	**TOTAL AVERAGE MONTHLY EXPENSES:**

What is your Current Fee? _____ What Fee are you requesting to pay?_____

How often do you see your therapist? ☐weekly ☐Every other week ☐monthly ☐_____

How often do you see your psychiatrist? ☐ N/A ☐weekly ☐every other week ☐monthly ☐quarterly

ADDITIONAL COMMENTS: _____

_____

_____

Return this form with supporting documents to your therapist or to Administrative Officer in our Elizabethtown Office.

For Office Use Only:

Fee Committee Decision:_____

_____

_____

Dept. Head_____ Date:_____