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| SERVICE LOCATION: |
| COMPLETE PAYOR SEQUENCE: |

FEE REDUCTION REQUEST FORM

CLIENT NAME: _____ AGE: _____ I.D. #: _____

RESPONSIBLE PARTY NAME AND ADDRESS: _____

PHONE #: _____

TOTAL HOUSEHOLD MEMBERS: _____

ANNUAL INCOME: _____ **(Income verification must be attached to form)**

ANNUAL EXPENSES: _____

If annual expenses exceed annual income, please explain: _____

I am requesting a reduction in my fee at New Mexico Solutions. I attest that this information is true and correct.

Applicant Signature

Date

THIS SECTION FOR INTERNAL USE ONLY

CURRENT DIAGNOSIS: _____

CLIENT HAS BEEN IN SERVICES SINCE: _____

ESTIMATED TIME TO CONTINUE SERVICES: _____

OF TIMES SEEN MONTHLY: _____

Therapist Signature

Date

CURRENT SELF-PAY BALANCE: _____

REQUESTED REDUCTION: _____

EXPLANATION FOR REDUCTION: _____

Business Office Signature

Date

THE BUSINESS OFFICE MUST SEND THE FEE REDUCTION REQUEST FORM AND ANY ATTACHED DOCUMENTATION VIA MAIL TO THE FINANCE DEPARTMENT AT THE REGIONAL OFFICE IN OWENSBORO. THE FINANCE DEPARTMENT WILL APPROVE OR DENY THE REQUEST AND RETURN SUCH REQUEST TO THE BUSINESS OFFICE.

Reduction Request: APPROVED, Fee Reduction Effective Until: _____ DENIED

C.F.O. Signature

Date