St. Clair County Community Mental Health

Request to Waive Assessed Ability to Pay or Fee Per Session

Individual: ____ Case #: _______________________

Annual Income: ______________________________________ Fee Assessed: _______________________

Fee Determination Effective Date: ____________________

Reason for Hardship: ____

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- Monthly Ability to Pay/Fee Per Session will be evaluated annually. If financial circumstances should change prior to the annual redetermination, it is the responsibility of the Individual/Responsible Party to notify SCCCMH.

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Individual/Responsible Party Signature Date

____ _______________________

FIPA Tech Signature Date

____ _______________________

Chief Clinical Officer Signature Date