

**INSERT YOUR LETTERHEAD HERE**

**WAIVER OF FULL CLIENT FEE AUTHORIZATION FORM**

- New
- Extension

Client Name: \_\_\_\_\_ Client SSN: \_\_\_\_\_  
Date of Admission: \_\_\_\_\_ Type of Service: \_\_\_\_\_  
Amount of Full Waiver: \_\_\_\_\_

All waivers must be accompanied by income eligibility documentation

**INABILITY TO PAY JUSTIFICATION & DOCUMENTATION:** Below check all those that apply:

- Financial Hardship**
- Homelessness** – without permanent address, without income, no disability income & no other income
- Student Assistance Assessment**
- Released from Jail** – from date of release from jail, a one time **30 day** waiver of fees if needed due to financial stresses.  
Date of Release: \_\_\_\_\_
- No Other income**
- Medicaid Spend-down** – as per the Insurance Benefit Policy
- Adolescents** – in addition to the above, Lack of Parental Involvement – refusal to pay
- Adolescents** – Lack of Parental Involvement – no parental signature/permission to bill insurance.

The above referenced client is eligible to have a fee waiver relative to his/her indigent status and his/her current inability to pay for the above services.

\_\_\_\_\_  
**Program Director's Signature** \_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client's Signature** \_\_\_\_\_  
**Date**

Begin Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Waiver Extension \_\_\_\_\_ Expiration Date \_\_\_\_\_

*Fee Waiver must be filed in client's file. Failure to have proper documentation in the client's file will be subject to adjustments.*