**PATIENT WAIVER/REDUCTION OF FEES APPLICATION**

As provided for by Federal Law, I hereby request that the [name of health center] make a written determination of my request to reduce or waive my out-of-pocket fees associated with services provided to me by [health center]. I verify that the information I submit is accurate and true and I authorize [health center] to verify the information by all necessary means. I also understand that if the information which I submit is determined to be false, such determination will result in denial of approval for waiver of fees and I will be liable for any balances on my account.

**The information requested will be held in the strictest of confidence and will be used solely for the purpose of determining waiver of health center fees**

Patient Name Date of Birth

Address Telephone

**REASON FOR WAIVER/REDUCTION REQUEST**

Please briefly describe the hardships you are facing that are preventing you from paying for the fees associated with services rendered at the Health Center:

**SIGNATURES**

PATIENT (OR GUARDIAN) DATE

FOR STAFF USE ONLY

**WAIVER/REDUCTION OF FEES DETERMINATION**

**TREATING PROVIDER CONSULTED** (**CIRCLE) YES / NO**

TREATING PROVIDER NAME (or Medical Director in Absence)

TREATING PROVIDER SIGNATURE DATE

**WILL FEES BE WAIVED OR REDUCED FOR THIS PATIENT? (CIRCLE) YES / NO**

BILLING DIRECTOR SIGNATURE DATE

CFO SIGNATURE (or CEO in CFO’s Absence) DATE

**IF FEES WILL/WILL NOT BE WAIVED/REDUCED, PLEASE EXPLAIN RATIONALE FOR DECISION**

IF YES, PLEASE INDICATE PERCENT OR AMOUNT OF FEES (OR TOTAL/100% IF ALL)

IF YES, PLEASE INDICATE TIMEFRAME FOR ELIGIBILITY OF WAIVER OF FEES