RIVERVALLEY BEHAVIORAL HEALTH

SERVICE LOCATION ______________________

FEE REDUCTION REQUEST FORM

COMPLETE PAYOR SEQUENCE ______________________

CLIENT NAME: ______________________ AGE: __________ I.D.# ______________________

RESPONSIBLE PARTY NAME AND ADDRESS: ______________________

______________________ PHONE #: ______________________

Total household members: ______________________

Annual Income: ______________________ (Must attach verification or will not be approved)

Annual Expenses: ______________________ (No verification needed)

If annual expenses exceed annual income, explain: ______________________

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I am requesting a reduction in my fee at RiverValley Behavioral Health. I attest that this information is true and correct.

______________________ ______________________

Signature Date

FOR OFFICE 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: ______________________

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______________________ ______________________

Business Office Signature Date

THE BUSINESS OFFICE MUST SEND THESE REQUESTS TO THE C.F.O. AT THE REGIONAL OFFICE FOR APPROVAL. THE C.F.O. WILL APPROVE OR DENY AND RETURN THE REQUEST TO THE BUSINESS OFFICE.

______________________ ______________________ ______________________

C.F.O. SIGNATURE DATE REDUCTION APPROVED/DENIED

Fee Reduction Effective Until ______________________

FLOW CHART -

CLIENT	BUSINESS OFFICE	PROFESSIONAL	BUSINESS OFFICE	PROGRAM DIRECTOR	BUSINESS OFFICE

WHITE - MEDICAL RECORDS CHART YELLOW - C.F.O. AT REGIONAL OFFICE PINK - BUSINESS OFFICE

DO NOT SEPARATE UNTIL ALL REQUIRED SIGNATURES HAVE BEEN OBTAINED

RV 373 - 10/06