rivervalley behavioral health

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 RiverValley Behavioral Health. 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**