

Program: _____

Division of Behavioral Health Services

Request for Fee Waiver/Reduction

(1) Client Demographics and Current UMDAP Information

Client Name: _____ Client ID: _____

Address: _____ S.S.N.: _____ - _____

_____ Daytime

UMDAP Period: _____ To _____ Telephone: _____

Present UMDAP Amount: \$ _____

Requested UMDAP Amount: \$ _____

Note: Attach copy of current UMDAP Financial Forms

(2) Client Explanation of Extraordinary Circumstances (include estimated time frame of need)

Client Comments: _____

Client Signature Date

I hereby certify that the above information is true to the best of my knowledge.

Note: Attach copy of documents to support the request.

(3) Service Coordinator Comments (include time frame and plan to follow up on need for waiver)

Service Coordinator Comments: _____

Service Coordinator Signature Date

(4) Supervisor/Administrator Comments (include plan to follow up on need)

Waiver/Reduction Granted ☐ Waiver/Reduction Denied ☐ New UMDAP Amount: _____

Effective Date: _____

Comments: _____

Supervisor/Administrator Signature Date

Please forward the original to Quality Management, Attention: Beneficiary Protection, 7001 E. Parkway Suite 300, Sacramento. CA 95823. Place a copy in the client record.