REQUEST TO WAIVE CONSUMER'S RESPONSIBILITY TO PAY FOR MEDICATIONS

CLINIC NAME: _____

DATE: _____ ACCOUNT NO: _____

TREATMENT STAFF: _____ CLIENT NO.: _____

CONSUMER NAME: _____

DEDUCTIBLE EXPIRATION DATE: _____

JUSTIFICATION FOR WAIVER:

A. MEDICATION PRESCRIBED AND DOSAGE PHARMACY COST

_____ _____ _____

_____ _____ _____

B. NEED FOR MEDICATION: _____

_____

C. FINANCIAL DATA: (Attach monthly expense statement)

CONSUMER'S STATED FAMILY GROSS MONTHLY INCOME: _____

FINANCIAL INTERVIEWER'S STATEMENT ABOUT FAMILY'S GROSS MONTHLY INCOME: _____

NO. OF PERSONS DEPENDENT ON INCOME: _____

IS THERE A CURRENT FEE REDUCTION WAIVER IN EFFECT? _____ DATE: _____

IF NO WAIVER IN EFFECT, WILL ONE BE REQUESTED? _____

D. ADDITIONAL INFORMATION:

_____

_____

REVIEWED BY PROGRAM MGR: _____

APPROVED: _____ DATE: _____ SIGNATURE: _____

DISAPPROVED: _____ DATE: _____ SIGNATURE: _____

REVIEWED BY DEPUTY DIRECTOR: _____

APPROVED: _____ DATE: _____ SIGNATURE: _____

DISAPPROVED: _____ DATE: _____ SIGNATURE: _____

REASON: _____

REVIEWED BY MEDICAL DIRECTOR: _____

APPROVED: _____ DATE: _____ SIGNATURE: _____

DISAPPROVED: _____ DATE: _____ SIGNATURE: _____

REASON: _____

IF APPROVED, THIS FORM IS VALID FOR 6 MONTHS OR UPON FI EXPIRATION DATE. EXPIRATION DATE IS:_____