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: ____

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__________________________________ ___________________________

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:____

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__________________________________ ___________________________

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: ____

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____________________________________ ___________________________

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.