St. Clair County Community Mental Health Authority

Request to Waive Assessed Ability to Pay or Fee Per Session

Individual: _____ Case #: _____

Annual Income: _____ Fee Assessed: _____

Fee Determination Effective Date: _____

Reason for Hardship: _____

_____

_____

_____

_____

_____

- *Monthly Ability to Pay/Fee Per Session will be evaluated annually. If financial circumstances should change prior to the annual redetermination, it is the responsibility of the Individual/Responsible Party to notify SCCCMH.*

_____ _____

Individual/Responsible Party Signature Date

_____ _____

FIPA Tech Signature Date

_____ _____

Program Director Signature Date