ADAMH

SHARES Public Subsidy Fee Waiver Request Form

A 90 day review is required to maintain waiver status. If this is a new waiver, check the "NEW Waiver" box. Otherwise, please check the "UPDATE" box to indicate that this form is to request an additional 90 days.

☐ NEW waiver
☐ UPDATE

Provider Agency Name:		**Date of Request:**	
Member Name:		**SHARES ID:**	
Person Requesting Waiver:		**Family Size:**	

Current Income (verified):		**Current fee % (Public Subsidy Schedule):**		**New requested fee % (Public Subsidy Schedule):**	

Requirements: Supporting documentation is required for submitting a waiver request, should be kept on file at the provider's office, and updated every 90 days.

Instructions: Please complete the form to the best of your ability. Use the space provided on page 2 for explanation.

1. Depending upon the circumstances of your request, all questions may not be applicable at the time of request. These items should be supplied to ADAMH as soon as possible, as they are required elements for enrollment.
    a. Ex: client is an immediate danger to self or others – income, family size, current fee- % pay may not be immediately available.
        i. If income and family size are not available due to the extreme case of danger to self or others, you may initially use "None" for income source and 1.00 for income amount. Use 1 for family size.
        ii. Remember: it is critical that you update this information as soon as possible with the correct information.
2. When selecting **"Other"** reasons for a waiver:
    a. Please be aware that the Franklin County ADAMH Board will review and notify you (in the Member Request Summary Notes) of the determination to grant or to not grant the waiver based on the reasons you identify.
    b. Submitting a waiver request for "Other" reasons is not a guarantee that the waiver will be approved.

WAIVER SUPPORT DETAIL

Clinical Exceptions to be Used for Waiver Request: Document the clinical reasons why you believe that this member requires services regardless of the member's or parent's ability to pay the fee for the service. **Check ALL that apply use the space provided on page 2 to provide support for the area(s) checked and explain the situation/circumstances:**

☐	**1.** This client is determined, by clinical judgment to be a danger to self or others (explain the situation/circumstances on page 2)
☐	**2.** An extreme or disruptive family situation resulting from fire, flood, storm damage or other circumstances which create an unusual demand on the family income during treatment. Explain what kind of event, date of the event, and how it affects the family financially. Also have available for attaching any insurance claims or police reports (if requested by ADAMH). (explain the situation/circumstances on page 2)
☐	**3.** A "breadwinner" who refuses to be responsible for the fee for service (explain the situation/circumstances on page 2)
☐	**4.** A "breadwinner's" knowledge of the service is clinically inappropriate (explain the situation/circumstances on page 2)
☐	**5.** Consistent with Federal taxes, if a family's behavioral health care, medical, and/or dental expense is greater than 10% of the Adjusted Gross Monthly Income, then the amount in excess of 10% will be documented and may be deducted from the Adjusted Monthly Gross Income. (attach relevant documentation)
☐	**6.** Consistent with Federal taxes, if a child or dependent care expenses are required to maintain employment, then a portion of the expense may be deducted in accordance with IRS guidelines. (attach relevant documentation)
☐	**7.** Other (explain the situation/circumstances on page 2- ***MUST BE APPROVED BY ADAMH BOARD***)

Please use the space provided below to provide support for the above area(s) checked.

Printed Name of Clinician providing the Services		**Date:**	
Signature of Clinician providing the Services:			