

## REQUEST FOR FEE REDUCTION

Date: \_\_\_\_\_

Client's Name: \_\_\_\_\_

Client's Social Security Number: \_\_\_\_\_

Nature of the clinical problem: \_\_\_\_\_

Family Income: \_\_\_\_\_

Family Size (including client): \_\_\_\_\_

Special financial circumstances affecting fee:

\_\_\_\_\_

Attached copy of verification:

\_\_\_\_\_ Income Tax Form

\_\_\_\_\_ Paycheck Stub

\_\_\_\_\_ Other – describe: