Request for Reductions/Elimination Checklist

Name: _____

Date of Birth: _____

SSN: _____

- ☐ Reduction /Elimination of Liability Form (attachment 3B)
- ☐ Liability Form (attachment 3A)
- ☐ Proof of Back Balance (if applicable)
- ☐ Budget-Attached

Date of Assessment: _____

Provider/Level of Care: _____

Drug of Choice: _____

MA active date (if applicable): _____

MA end date (if applicable): _____

Date MA applied/reapplied for: _____

Private Insurance (if applicable):_____

___Co-Pay Information: Amount per visit $_____Per visit

___Deductible Request Information: Insurance Deductible Requirement:

_____

_____

NOTES: Please proved any other information that will support the decision on abatement:

_____

_____

PERSONAL BUDGET WORKSHEET

(Spending Plan)

	MONTH:	
INCOME:	Budget	Actual
Salary		
Partner's Salary		
Public Assistance		
Food Stamps		
Other:		
Total Income	$ -	$ -
EXPENSES:		
Living/Housing:		
Rent/Mortgage		$ -
Electric		$ -
Water/Sewer		$ -
Gas/Heating		$ -
Telephone		$ -
Cable TV		$ -
Household/Repairs		$ -
Other:		$ -
Transportation:		
Gas/Auto Expenses		$ -
Bus, Taxi, Train, etc.		$ -
Parking		$ -
Other:		$ -
Other:		$ -
Miscellaneous:		
Church		$ -
Gifts/Charity		$ -
Savings		$ -
Other:		$ -
Other:		$ -
Total Expenses:	$ -	$ -
TOTAL INCOME MINUS TOTAL EXPENSES:	$ -	$ -