COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
THERAPEUTIC FEE ADJUSTMENT REQUEST

Date: _____

TO: _____
Program Head

FROM: _____
Clinician

SUBJECT: **REQUEST FOR THERAPEUTIC FEE ADJUSTMENT**

I understand that this fee adjustment is subject to the approval of the clinic Program Head. The above mentioned therapist has explained the fee adjustment process to me. I am aware that, if approved and in the event I fail to pay a reduced amount in accordance with the attached agreement, the original UMDAP liability amount will be reinstated and any payments will be credited toward that amount. This balance may then be forwarded to the Office of the Los Angeles County Treasurer and Tax Collector for collection.

_____
Client's Signature

Client's Name _____

MIS Number _____ UMDAP Period _____

Current UMDAP Liability $_____ Recommended Amount $_____

Anticipated Number of Visits _____

Reason for Request

Approved by: _____
Signature of Program Head