REQUEST FOR LIABILITY REDUCTION OR ELIMINATION

CLIENT'S NAME:	CLIENT ID #
AGENCY NAME:	

I am requesting an adjustment to my liability for the following reason(s): _____
_____
_____

_____ ____/____/____
Client / Liable Person Signature Date

I hereby request a review by the SCA Administrator (Designee) of this client's assessed liability. I request that the liability be ***(check one from each column)*** :

□ Abated in full

□ For the period: ___/___/___ to ___/___/___

□ Current Liability of _____Modified to _____

□ Ongoing

This abatement is being requested due to:

□ Clinical Reasons

□ Substantial Financial Hardship

Description of reason (be specific):
_____
_____
_____
_____

□ I certify that to the best of my knowledge and belief, the imposition of the assessed liability would be likely to negate the effectiveness of treatment, or prohibit the client's access to, or continuation of, treatment and that failure to provide such treatment would result in serious harm to the client's welfare or in greater cost to the Commonwealth due to deterioration in the client's condition.

□ I do not support the request for reduction or elimination of liability at this time.

_____ _____
Date Staff Signature, Title

----------**SCA USE**----------

□ Approved

□ Partial Approval as Follows: _____
_____
_____

□ Denied

_____ _____
Effective Date SCA or Designee Signature, Title