ABILITY TO PAY – FEE ACTION REQUEST

ND DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 196 (Rev. 9-2011)

Clear Fields

Completed by Initiator of Request

Client Name:	Client ID:	Human Service Center:

Please check the appropriate box(es) below:

☐ ____ % discount (10% increments only): Date of Service From _____ Thru _____
NOTE: Date thru not to exceed 12 months or lapse date of the current private pay layer (whichever is sooner).

☐ Medical Assistance Recipient Liability: Date of Service From _____ Thru _____
☐ Medicare Deductible/Coinsurance: Date of Service From _____ Thru _____
☐ Title XIX Extenuating Circumstance: Date of Service From _____ Thru _____
☐ Do NOT send to collections -- Review in____ months (not to exceed 3 months)
☐ Do NOT send statements -- Review in ____ months (not to exceed 3 months)
☐ Other (specify) _____
Review in ____ months (not to exceed 12 months)

Additional Discount Type (choose only one):

☐ Administrative Decision
☐ Countertherapeutic
☐ Financial Hardship
* Complete Income and Expenses
☐ Protective Services
(List specific services below)

***Financial Hardships: Monthly Income and Expenses must be completed for all Financial Hardships.**

MONTHLY INCOME	MONTHLY EXPENSES
TOTAL	TOTAL

Describe the uniqueness of the client's situation (please be specific): (You may attach additional sheets if necessary)

Impact on client if not approved:

For Business Office Use Only

Discount %: Original _____ Additional _____ Final _____	Effective Date
Comments:	

Initiator of Request:	Date:
Unit Supervisor:	Date:
Regional HSC Fiscal Manager:	Date:
Regional Director:	Date:
ROAP Receivables Specialist:	Input Date: