

**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 Name \_\_\_\_\_

MIS Number \_\_\_\_\_ UMDAP Period \_\_\_\_\_

Current UMDAP Liability \$ \_\_\_\_\_ Recommended Amount \$ \_\_\_\_\_

Anticipated Number of Visits \_\_\_\_\_

Reason for Request \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Approved by: \_\_\_\_\_  
Signature of Program Head