

**MCCMH-SUD Recovery Home Fee Waiver**

Client Name: \_\_\_\_\_  
Recovery House: \_\_\_\_\_  
House Fax #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
Employee Name: \_\_\_\_\_  
Date of Request: \_\_\_\_\_

The recovery home provider attests that after careful review that an extreme circumstance or hardship exists that temporarily prohibits a client from being able to meet the copay responsible for reauthorized recovery home services and is seeking a co-pay waiver based on at least one of the following:

- Client recently lost employment and is unable to contribute to recovery housing costs
- Client experience an unexpected medical condition/illness and is currently unable to contribute to recovery housing costs
- Client has been actively seeking work as verified by the house but unable to find employment
- Other (explain): \_\_\_\_\_  
\_\_\_\_\_

Home Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Fax this request to MCCMH-SUD at 586-469-5568**

|  |             |
|--|-------------|
| <b>MCCMH-SUD Response</b>                                  |             |
| Date received: _____                                       |             |
| Request: <input type="checkbox"/> Approved                 |             |
| <input type="checkbox"/> Denied – Reason for denial: _____ |             |
| _____  |             |
| MCCMH-SUD Signature: _____                                 | Date: _____ |
| Date faxed to recovery home: _____                         |             |