REQUEST FOR COUNTY ADMINISTRATOR REVIEW
(CLINICAL REASONS)

CLIENT'S NAME:	CLIENT CASE #
LIABLE PERSON'S NAME (*IF DIFFERENT FROM CLIENT)*:	AGENCY NAME AND CONTACT:

I hereby request the review by the County Administrator of this liable person's maximum liability. I request that this liability be:

☐ ADJUSTED TO 0
☐ ADJUSTED TO _____ PER MONTH

I hereby certify that to the best of my knowledge and belief, the imposition of this liability would be likely to negate the effectiveness of treatment or prohibit the client's entry into treatment. I further certify that, to the best of my knowledge and belief, the 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. The grounds for such belief are fully spelled out in the client's record.

_____ _____
SIGNATURE OF MH OR ID TREATING PROFESSIONAL DATE

_____
PRINT NAME AND TITLE