MACOMB COUNTY COMMUNITY MENTAL HEALTH

REQUEST FOR WAIVER OF FEES
FREEDOM OF INFORMATION ACT

NAME: _____ TELEPHONE NO. _____
STREET ADDRESS _____ CITY & STATE _____
ZIP _____

I HAVE REQUESTED COPIES OF CERTAIN DOCUMENTS AND/OR RECORDS FROM MACOMB COUNTY COMMUNITY MENTAL HEALTH AS DESCRIBED IN AN INFORMATION REQUEST DATED _____. I BELIEVE THAT I QUALIFY FOR A WAIVER OF FEES UNDER THE FREEDOM OF INFORMATION ACT AND COUNTY POLICY. I AM REQUESTING WAIVER OF FEES IN THE AMOUNT OF $_____.

I BELIEVE THAT I QUALIFY FOR THE WAIVER BECAUSE:

□ I AM RECEIVING PUBLIC ASSISTANCE (AID TO DEPENDENT CHILDREN, GENERAL ASSISTANCE, ETC. (Complete the section below)

□ I AM INDIGENT. MY FAMILY INCOME (ANNUAL INCOME) IS BELOW FEDERAL POVERTY GUIDELINES. (proof of income may be required)

ARE YOU RECEIVING ANY OF THE FOLLOWING: (fill in case number or claim number)

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_____

WORKMEN'S COMPENSATION _____ SOCIAL SECURITY _____
GENERAL ASSISTANCE _____ SSI _____
AID TO DEPENDENT CHILDREN _____ OTHER _____
I PREVIOUSLY REQUESTED THE SAME DOCUMENTS: YES _____ NO _____

COMMENTS:

I HEREBY ACKNOWLEDGE THAT I HAVE READ THE FOREGOING AND DO HEREBY CERTIFY THAT THE STATEMENTS CONTAINED THEREIN ARE TRUE.

DATE _____ SIGNATURE _____

For Agency use only
The request for waiver of fees has been reviewed and the waiver □ is □ is not authorized.

DATE _____ SIGNATURE_____
Executive Director