



DRIVER REHABILITATION PROGRAM

APPLICATION FOR REDUCED FEE
FINANCIAL INFORMATION

Date: _____

Client's Name: _____

Medicare Number: _____

Medicaid Number: _____

Monthly Income (if married, income must include spouse):

1. Social Security _____
2. S.S.I. _____
3. Pension _____
4. Interest, Stocks, etc. _____
5. Employment _____
6. Other _____

Average Total Monthly Income \$ _____

Living Arrangements

- Self With spouse Other relative

Other assistance being provided in the home (i.e., Home Health Care): _____

Responsible Party: _____

Billing Address: _____

Phone: _____

Signature