cbes
Central Boston Elder Services
Your connection to care

Application for Co-payment Adjustment

CM/CIS: _____ Application Date: _____

Consumer Name: _____ Marital Status: _____

Client Id: _____ Spouse's Client ID: _____

Applicant
Annual Gross income: _____

Household
Annual Gross income: _____

Program Enrollment: _____ Co-payment ($ or %) _____

Proposed Adjust Cost Shre (Cost Share or Percentage of Service Cost): _____

Reason for Co-pay Adjustment Request			
Hardship Category (check all that apply)		Hardship Details	Monthly Expenses (enter all applicable)
☐ Medical Finances		Health Care Insurance:	
		Medications:	
☐ Household Finances		Rent or Mortgage:	
		Utilities :	
		Food/Groceries:	
☐ Other (list in hardship details):	1.		
	2.		
	3.		

Grand Total: $ 0.00

Co-Payment Adjustment Review	
☐ Approved	☐ Deferred ☐ Denied
New Co-Paid ($ or %): _____	**Reason:**
Approved Adjustment Time Period (default is 'Next RD' or specify duration or date):	

Revised March 3, 2025

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_____	_____
Authorized by (Print):	Authorized BY (Title):
_____	_____
Authorized by (Signature):	Date: