



YourBankruptcyPartner.com

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www.ybpcert.com

Fee Waiver Request Form

Please fill out this approval form to create an account with YourBankruptcyPartner.com, Credit Advisors Foundation (Pre-Filing Credit Counseling), and Arbor Investments (Post-Filing Debtor Education). We will review your information provided below. Eligibility for a fee waiver will be based on income less than 150 percent of the poverty guidelines published by the United States Department of Health and Human Services (see chart below).

Client's Name: _____ Last 4 of SSN: _____

Spouse's Name: _____ Last 4 of SSN: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____ Email Address: _____

Attorney's Name: _____ Phone: _____

Attorney's Email: _____ Fax: _____

Delivery preference for client certificate delivery: Email / Fax / Mail _____

I am requesting a fee waiver for: _____ Credit Counseling (Pre-Filing) _____ Debtor Education (Post-Filing)

How many people are currently living within your household? _____

What is your total household income before taxes? \$ _____ Monthly



Did you receive a waiver for the bankruptcy court filing fee? No Filing Chapter: Chapter 7

Is Attorney working on your case Pro Bono? No Creditors currently garnishing your wages?



What is the reason for your financial hardship? _____

Please submit the following 2 documents for review: This Fee Waiver form and Schedule I (if prepared) or Proof of Income such as 1 month pay, unemployment, or disability stubs.

Return the required documents to us by one of the following methods and you will be contacted within 1-2 business days with the results of your request.

Email: feewaiver@yourbankruptcypartner.com

Fax: 402.393.1579

Mail: Credit Advisors, Bankruptcy Dept, 1850 S. 72nd St., Omaha, NE 68124

I hereby affirm that the information being provided to Credit Advisors Foundation and Arbor Investments is complete and accurate. I understand that the information provided above may be required to be verified by Credit Advisors Foundation and Arbor investments. I authorize the investigation of all statements contained in this application as may be necessary in arriving at a decision on this application.

Attorney or Client's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

150% of the HHS Poverty Guidelines for 2026* Monthly Basis			
Persons in family unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$1,995.00	\$2,493.75	\$2,295.00
2	\$2,705.00	\$3,381.25	\$3,111.25
3	\$3,415.00	\$4,268.75	\$3,927.50
4	\$4,125.00	\$5,156.25	\$4,743.75
5	\$4,835.00	\$6,043.75	\$5,560.00
6	\$5,545.00	\$6,931.25	\$6,376.25
7	\$6,255.00	\$7,818.75	\$7,192.50
8	\$6,965.00	\$8,706.25	\$8,008.75
For each additional person add	\$710.00	\$887.50	\$816.25
* As required by section 673(2) of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97-35 - reauthorized by Pub. L. 105-285, Section 201 (1988)).			

150% of the HHS Poverty Guidelines for 2026* Annual Basis			
Persons in family unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$23,940	\$29,925	\$27,540
2	\$32,460	\$40,575	\$37,335
3	\$40,980	\$51,225	\$47,130
4	\$49,500	\$61,875	\$56,925
5	\$58,020	\$72,525	\$66,720
6	\$66,540	\$83,175	\$76,515
7	\$75,060	\$93,825	\$86,310
8	\$83,580	\$104,475	\$96,105
For each additional person add	\$8,520	\$10,650	\$9,795
* As required by section 673(2) of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97-35 - reauthorized by Pub. L. 105-285, Section 201 (1988)).			