St. Clair County Community Mental Health Authority

Request for a New Rate Determination

Individual: _____ Case #: _____

Responsible Party: _____

I am requesting that the fee assessment of $ _____ with effective date of _____ be recomputed based upon the additional information that I will provide (e.g. decrease/increase wages, settlements, retroactive income, expenses, proof of undue financial hardship, etc.)

Reason:

*_____ _____

Individual/Responsible Party Date

_____ _____

FIPA Tech Signature Date

*My signature indicates I understand that I have 30 days to complete this process or my original fee assessment will be effective from the first date of service.

Clinical Form: #03-0007
Revised Date: 9/1/2023
Policy Ref: #03-002-0025, #07-003-0025, #07-003-0030
EHR: Administrative/Financial, Fee Determination/Payment Agreements, Outpatient Fee Determination