

St. Clair County Community Mental Health Authority

## Medicaid Deductible Worksheet

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Individual: \_\_\_\_\_ Case #: \_\_\_\_\_

Payment Effective Date: \_\_\_\_\_

1. Monthly Personal Liability for Mental Health Services (Line 3.e. of "Fee Determination for Mental Health Services for Monthly Payments-Specialized Group/Foster Homes or Inpatient > 60 Days," form #118) \$ \_\_\_\_\_
2. Medicaid Deductible Amount \$ \_\_\_\_\_  
*(Attach Supporting Documentation to FIPA )*
3. Enter the lesser of Line 1 or Line 2 \$ \_\_\_\_\_
4. Enter amount from Line 3 on the "Residential Summary and Signature Page", form #116. This amount is the individual's monthly ability to pay for mental health services.