St. Clair County Community Mental Health

Medicaid Deductible Worksheet

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.