Lawrence County Health Department – Behavior Health Department
2101 James Street, Lawrenceville, IL 62439 (618) 943-3302

BEHAVIOR HEALTH FEE ASSESSMENT W/ SUPR GRANT

Name: _____ **ID#:** _____ Date: _____

	Medicaid		Insurance		Self-Pay		SUPR Grant
Spend-Down		Yes		No	Spend-Down Amount	$	

Applied for Medicaid: YES NO REFUSED **Proof of Income has been obtained and is attached:** YES NO
Source of proof of income: (D) Document (pay stub, tax form, etc…) (C) Consumer attestation (Notarized letter from someone who knows consumer's situation) (G) Consumer parent/guardian attestation (P) Provider attestation

Note: Proof of ENTIRE household income is required to be on file to qualify for adjusted fees.

Monthly Income Type	Amount
Wages/Self Employment	$
Unemployment	$
Social Security	$
Disability	$
DHS Cash Assistance	$
Child Support	$
Food Stamps	$
Other (Specify _____)	$
Total Monthly Household Income	$
Total # of Persons Currently Living in Household (including Client)	
Adjusted Fee Share for services not covered by DHS/Federal Poverty Level	$
Adjusted Fee Share assessed by billing/SUPR Grant	$

FULL FEE - $175 PER HOUR/Treatment, $200 PER HOUR/Intake and Review, $350 PER HOUR/ Psych Eval

Insurance Clients: We will bill your insurance for you. Your maximum out-of-pocket will NOT exceed your Fee Share. Fee Share is based on your household income and number of person(s) in your household. You will be billed any outstanding amount.

Insurance/Medicaid/MCO Clients: Insurance will be billed first. The remainder will be billed to Medicaid
Self-Pay Clients: Your fees and services will be based on your income group, services provided, and consumer eligibility guidelines. Fees will vary for therapy/counseling and psychiatry visits. Payment is expected at time of service.

I understand the guidelines regarding fee payment for services and agree to abide by these guidelines. I agree to pay my fee share if applicable at time of service. I understand that the above total is an estimate, and my actual costs may be more or less than that amount. I received and or been read a copy of the fee schedule and related policies. I understand that in the event I have a delinquent account in the future, debt collection may be turned over to a collection agency and I would be responsible for any fees and costs associated with any debt collection efforts, to include any attorney's fees associated therewith.

Client/Guardian Signature: _____ **Date:** _____

Fee Assessed by: _____ **Date:** _____ **Time:** _____

*Staff has read this document to the client/guardian and answered any questions. Collect fee share for first appointment.

CLIENT ID#: _____ Revised: 09/08/2026

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2026 Poverty Guidelines

Persons in family/household	Poverty Guideline Annual	Group A <250%	Group B <300%	Group C <350%	Group D >351%
1	$15,960	$0 - 3,325	3,326 - 3,990	3,991 - 4,655	4,656 - 100,000
2	$21,640	$0 - 4,508	4,509 - 5,410	5,411 - 6,311	6,312 - 100,000
3	$27,320	$0 - 5,691	5,692 - 6,830	6,831 - 7,968	7,969 - 100,000
4	$33,000	$0 - 6,875	6,876 - 8,250	8,251 - 9,625	9,626 - 100,000
5	$38,680	$0 - 8,058	8,059 - 9,670	9,671 - 11,281	11,282 - 100,000
6	$44,360	$0 - 9,241	9,242 - 11,090	11,091 - 12,938	12,939 - 100,000
7	$50,040	$0 - 10,425	10,426 - 12,510	12,511 - 14,595	14,596 - 100,000
8	$55,720	$0 - 11,608	11,609 - 13,930	13,931 - 16,251	16,252 - 100,000

CLIENT ID#: _____

Revised: 09/08/2026