

Effective Date: _____ Admission Status: Pre-Registered Registered Admit Update
 Provider #: _____ Name: _____ Unit #: _____ Sub-Unit#: _____

CLIENT IDENTIFYING INFORMATION

Name: First: _____ Middle: _____ Last: _____
 Suffix: _____
 Address: _____ Home Ph: () _____
 City/State/Zip: _____ Cell Ph: () _____
 With-in City Limits? Yes No County of Residence: _____ Work: () _____
 Employer: _____
 SSN: _____ If blank, reason SSN not provided: _____
 DOB: _____ Gross Monthly Income: \$ _____
 # of children living with you: _____ # in household: _____

Please circle one item in each category

Gender: Male Female **Marital Status:** Never Married Married Widow Divorce Separated Common Law
Race: White Black/African American Asian American Indian/Alaskan Native Bi-Racial
 Native Hawaiian/Pacific Islander Other: _____
Hispanic Origin: Puerto Rican Cuban Mexican Other: _____
Employment Status: Un-employed Part time Full time Disabled Retired Homemaker Student
Occupation: Clerical Craftsman Laborer Managers Military Operatives/Mech Professional Sales
 Service / household Other: _____
Living Arrangements: Living w/both parents Living w/single parent Living w/other _____ Living alone
 Nursing Home Foster Home Transitional/Supported living Jail/Correctional facility Homeless RCF
Veteran: Yes No
Education: Kindergarten 1st-12th Grade ____ (indicate grade) GED College (# of years) _____ No Academic
Hearing Status: Normal Hard of hearing Deaf Unknown
Preferred Language: English Spanish Other: _____
Referred by: Family Friend Self Former client Medical Dr. Hospital/ER School Dept of Social Services
 Court/Law Enforcement Probation/Parole Drug Court MH Court Internet/Other advertising Insurance Co.
 Other: _____
Legal Status: Does not apply Awaiting Disposition Probation Parole
 If on P & P, Officer name: _____
 Office Location & Ph#: _____

Client Name: _____ MR#: _____

The questions in the following 2 boxes refer to the **Insured Person's** information.

Primary Insurance				<input type="checkbox"/> self	<input type="checkbox"/> parent	<input type="checkbox"/> spouse	<input type="checkbox"/> guardian	DOB: _____
Name: _____								SSN: _____
Address: _____		Last		First		M.I.		
								Home Ph (____) _____
Employer: _____								Work Ph: (____) _____
Insurance Co: _____								Plan Name: _____
I.D. #: _____								Group# _____

Secondary Insurance				<input type="checkbox"/> self	<input type="checkbox"/> parent	<input type="checkbox"/> spouse	<input type="checkbox"/> guardian	DOB: _____
Name: _____								SSN: _____
Address: _____		Last		First		M.I.		
								Home Ph (____) _____
Employer: _____								Work Ph: (____) _____
Insurance Co: _____								Plan Name: _____
I.D. # _____								Group# _____

Alias(es)

Last Name: _____	First: _____	Middle: _____
Last Name: _____	First: _____	Middle: _____
Last Name: _____	First: _____	Middle: _____

Emergency Contact

Name: _____	Relationship: _____	Ph#: _____
Name: _____	Relationship: _____	Ph#: _____

Advance Directive Statement: I have an Advance Healthcare Directive: Yes No N/A Unknown

Responsible Party

Name: _____	Relationship: _____	Ph#: _____
Address: _____		Cell: _____
Employer: _____		Wk #: _____

Family Members Currently in Service

Name: _____	Relationship: _____	<u>Is this person in your care?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Name: _____	Relationship: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Name: _____	Relationship: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

The following will be completed by staff:

PAYORS:	(1)	(2)	(3)	(4)	(5)	(6)
	(7)	(8)	DMH Co-pay: \$ _____			
Diagnosis: Provide DSM diagnosis for Axis I, II, IV and V; Axis III is coded from ICD 9 M for physical health:						
Axis I	Axis II	Axis III	Axis IV	Axis V		
Primary: _____						
Secondary: _____						

Client's Name: _____ MR #: _____

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Rediscover

Initials

I understand it is my responsibility to notify ReDiscover of any change in my status such as:

- a) Insurance coverage
- b) Medicaid or Medicare coverage
- c) Income and/or employment
- d) address and/or phone number

I authorize my payor source(s) to pay ReDiscover any benefits due for services rendered and understand that ReDiscover will release my information as necessary to process my claims.

I understand I am financially responsible for any charges not covered by my payor(s) including co-pays, deductibles, or co-insurance as determined by my Insurance Plans.

I understand if I do not keep my account current, ReDiscover has the right to suspend my treatment until my account is made current. I further understand that if I choose to discontinue treatment, I am still responsible for the full balance due, and that my unpaid balance may be referred to a collection agency.

I acknowledge ReDiscover has the right to release any information acquired during my assessment and treatment (including alcohol/drug use or HIV testing or status, if applicable) that is necessary to process payment for my services.

I understand that my information and treatment records are strictly confidential, and will only be released with my written permission or as specified by law.

I authorize ReDiscover to provide the treatment deemed necessary to improve the emotional well being of the client named below.

I acknowledge receiving a copy of ReDiscover's Client Handbook which includes:

- a) My Rights and Responsibilities as a client.
- b) Notice of Privacy Practices
- c) the process for filing/resolving concerns/ grievances

I have an Advance Healthcare Directive: Yes No N/A Unknown

Client or Authorized Representative Signature: _____

Date: _____

Witness Signature: _____

Date: _____

Client Name _____

MR # _____

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ReDiscover



STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH___
NOTICE OF COST

The charges and cost for _____, Case No. _____, a client of _____, receiving care and treatment at _____, have been determined to be

▶ _____ per month for care and/or treatment effective _____.
The actual cost per month varies according to the services provided.

OR _____ per month for treatment effective _____.
The actual cost per month is _____.

Client or Responsible Party is required to provide insurance information.

Failure to release this information will result in the charges to be assessed at actual cost.

Insurance companies will be billed the actual cost of the service(s) provided.

The charges were determined by application of the STANDARD MEANS TEST (Section 630.210, RSMo. and 9 CSR 10-31.011). The cost is the Department of Mental Health's actual cost of providing the services or its contract cost for purchasing the service. The department's cost is recomputed annually. The charge is re-determined annually or at any time it is known that _____ occurred in the financial ability of the client (or the person responsible for the client) to pay.

The difference between the cost of care and treatment and the amounts received in payment may be a claim upon the client's estate at death by the Department of Mental Health (Section 473.398, RSMo.).

If proper payments are not maintained, the state reserves the right to initiate payment enforcement proceedings.

If you have questions about the cost of care or the amount being charged, contact the facility issuing this notice.

SIGNATURE OF CLIENT OR FINANCIALLY RESPONSIBLE PERSON X	WITNESS	DATE
OR The client or financially responsible person refused to sign this notice in my presence:	WITNESS	DATE
OR This notice was sent by mail on	DATE	SIGNATURE



STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
STANDARD MEANS TEST FINANCIAL QUESTIONNAIRE

FACILITY		DATE	CLIENT'S DOB	CLIENT'S SOCIAL SECURITY NUMBER		
CLIENT'S LAST NAME		FIRST	M.I.	CASE NUMBER	DATE ADMITTED	MEDICARE NUMBER
MEDICAID NUMBER	IF SCHOOL-AGED, NAME OF DOMICILE SCHOOL DISTRICT			NO. IN HOUSEHOLD	IF VETERAN, DATES OF SERVICE	
BRANCH OF SERVICE		SERVICE NUMBER	PREVIOUS ADDRESS (IF CHANGED IN LAST 6 MONTHS)			
NAME OF PERSON TO BE BILLED			STREET ADDRESS		CITY-STATE-ZIP	PHONE

(A) Does Client Have Health Insurance? Yes No

POLICYHOLDER	NAME AND ADDRESS OF HEALTH INSURANCE COMPANY		POLICY/GROUP NUMBER
	Name:	Ph.	
	Address:		
	Name:	Ph.	
	Address:		

(B) Is Client And/Or Financially Responsible Person of Client Employed? Yes No

NAME OF PERSON EMPLOYED	NAME AND ADDRESS OF EMPLOYER		
	Name:	Ph.	
	Address:		
	Name:	Ph.	
	Address:		

(C) Income

LINE NO.	SOURCES OF INCOME	INCOME OF CLIENT				INCOME OF SPOUSE OR PARENT(S)			
		YES	NO	AMOUNT	PAY PERIOD	YES	NO	AMOUNT	PAY PERIOD
1	Armed Forces Allotment								
2	Boarders/Lodgers (Taxable Income)				Month				Month
3	Bonuses								
4	Child Support								
5	Civil Service Retirement								
6	Dividends and Interest				Month				Month
7	Maintenance (Alimony)				Month				Month
8	Military Retirement				Month				Month
9	Pensions (Company and Union)								
10	Railroad Retirement				Month				Month
11	Rents (Taxable Income)								
12	Salary or Wages (Gross)								
13	Self-Employment (Taxable Income)								
14	Social Security				Month				Month
15	S.S.I.				Month				Month
16	Tips and Gratuities								
17	Unemployment Compensation				Week				Week
18	Veterans Benefits				Month				Month
19	Workers Compensation				2 Weeks				2 Weeks
20	Other								

(D) Income Conversion (For Department of Mental Health Use Only)

LINE NO. SECT. (C)	AMOUNT	PAY PERIOD	MULTIPLIER X	MONTHLY INCOME	LINE NO. SECT. (C)	AMOUNT	PAY PERIOD	MULTIPLIER X	MONTHLY INCOME
Less: Extraordinary Medical Expenses					Less: Extraordinary Medical Expenses				
Total Monthly Income					Total Monthly Income				
Rate Per Month From Standard Means Test Table \$					Rate Per Month From Standard Means Test Table \$				

(E) Is Any Other Member Of Your Household Receiving Services Through (By) DMH? Yes No

If two or more members of a household receive services in the same month, the Provider shall charge no more than the amounts determined for one recipient.

(F) Does Someone Else Receive Client's Government Check? Yes No

Name: _____ Street Address: _____

City: _____ State/Zip: _____ Ph. _____

(G) Name of Parents or Spouse, If Applicable

NAME			RELATIONSHIP TO CLIENT	DATE OF BIRTH	DATE OF DEATH	SOCIAL SECURITY NO.	VETERAN?	
FIRST	M.I.	LAST					YES	NO

Sections H through J is to be omitted if client is not long term.

(H) Does Client And/Or Client's Spouse Have Personal Property? Yes No

DESCRIPTION	YES	NO	IN WHOSE NAME	LOCATION	VALUE
Bonds					
Business Equipment					
Cash					
Checking Account					
Farm Equipment					
Farm Grain and Produce					
Farm Livestock					
Farm Machinery					
Loans (Not Secured)					
Mobile Home					
Mortgages Owed To You					
Notes Owed To You					
Claims in Probate Court					
Savings Account					
Stock					
Time Certificates					
Trust Funds					
Other					

(I) Does Client And/Or Client's Spouse Own Real Property? Yes No

DESCRIPTION AND LOCATION OF REAL PROPERTY	WHOSE NAME IS ON THE DEED?	WHO HOLDS THE MORTGAGE?	CURRENT VALUE	AMOUNT OWED?

(J) Does Client Have Life Insurance And/Or A Prepaid Burial Plan? Yes No

NAME OF COMPANY	TYPE	POLICY NO.	FACE VALUE	PREMIUM	HOW OFTEN PAID?
	Burial				
	Life				

(K) Remarks

(L) Certification

I hereby certify that I have not knowingly withheld any information on income or other financial resources and the amounts I have disclosed are true and correct to the best of my knowledge.

SIGNATURE _____

RELATIONSHIP TO CLIENT _____ DATE _____

SIGNATURE OF INTERVIEWER _____ DATE _____