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 receipient.

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

STATE OF MISSOURI
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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 redetermined annually or at any time it is known that changes have 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	