STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
SCL NOTICE OF PLACEMENT

NAME OF CLIENT	DMH ID NUMBER	SOCIAL SECURITY NUMBER
RESIDENTIAL PROVIDER	VENDOR NUMBER	DATE OF PLACEMENT
PREVIOUS PLACEMENT FACILITY	SEX	DATE OF BIRTH
INITIATED BY (COMMUNITY PROVIDER)	CASEWORKER/CASE MANAGER	PHONE

The following will be included on the contract:

EXPENSES	Partial Month	Full Month		Partial Month	Full Month	**PAYMENT SOURCES**	Partial	Full
Facility Base Rate			*Transportation			SSI		
Apartment Rent Actual			*Rent Deposit			SSDI		
*Apartment Rent Max			*Application Fee			†Earnings		
*Utilities			*Phone Installation			DFS Grant		
*Food			*Other Start-Up			Other		
*Personal Allowance			*Other (Specify)			DMH		
			Total of Expenses			Total of Payments		

* REGIONAL LIMITS APPLY

† EARNINGS CONTRIBUTION = (1 MONTH NET INCOME - $100) X 40%

PAYEE OR RESPONSIBLE PARTY NAME	PAYEE OR RESPONSIBLE PARTY ADDRESS

COMMENTS:

CASEWORKER/CASE MANAGER	DATE	PROVIDER SUPERVISOR W/ SIGNATURE AUTHORITY	DATE
SCL CASE MONITOR	DATE	SCL DIRECTOR	DATE