



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	MI	CASE NUMBER		DATE ADMITTED		MEDICARE NUMBER	
MEDICAID NUMBER		If school aged – Name of Domicile School District			NUMBER 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? <input type="checkbox"/> YES <input type="checkbox"/> NO										
POLICYHOLDER		NAME AND ADDRESS OF HEALTH INSURANCE COMPANY					POLICY / GROUP NUMBER			
(B) Is Client And/Or Financially Responsible Person of Client Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No										
NAME OF PERSON EMPLOYED			NAME AND ADDRESS OF EMPLOYER							
			NAME:					PHONE:		
			ADDRESS:							
			NAME:					PHONE:		
			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)									
3	Bonuses									
4	Child Support									
5	Civil Service Retirement									
6	Dividends and Interest									
7	Maintenance (Alimony)									
8	Military Retirement									
9	Pensions (Company & Union)									
10	Railroad Retirement									
11	Rents (Taxable Income)									
12	Salary or Wages (Gross)									
13	Self-Employment (Taxable Income)									
14	Social Security									
15	S.S.I.									
16	Tips and Gratuity									
17	Unemployment Compensation									
18	Veteran's Benefits									
19	Worker's Compensation									
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: _____ Phone: _____

(G) NAME OF PARENTS OR SPOUSE, IF APPLICABLE

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

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

(H) Does Client And/Or Client's Spouse Have Personal Property?

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?

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 NUMBER	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 _____