_____
Consumer Name and Consumer DMH ID #

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, _____

(client, guardian, or parent of minor client)

acknowledge that I have received the Notice of Privacy Practices with an effective date of October 24, 2013.

Signature of client, guardian, or parent of minor client:	Date:
_____ **at** _____**p.m./a.m.** **Date/Time sent to guardian** *(if applicable)*	**Signature of presenter / sender**

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

APPLICATION FOR SUPPORTED COMMUNITY LIVING SERVICES

I, _____ ,
(client, guardian, or parent of minor client)

make application for _____
(client)

to receive Supported Community Living services.

I authorize my* referral to appropriate community residential facilities. I authorize Missouri Department of Mental Health, Division of Comprehensive Psychiatric Services Supported Community Living staff to provide direct targeted case management when necessary for continuation of housing. I also authorize the release of information about me* to those community residential facilities in order to determine if those facilities will consider accepting me*. I understand that any facility at which placement is made is inspected and licensed by the Missouri Department of Mental Health and/or the Missouri Department of Health and Senior Services. I understand that I have the right to visit the facility prior to placement, and that I can refuse placement at any specific residential facility.

I understand that I* or a responsible party, if any, is responsible to support and maintain me* based on ability to pay. I understand that all earned or unearned income and other assets of mine* must be reported to the regional Supported Community Living program and that I* or a responsible party may be required to pay part or all of these assets for my* care. Assets include SSDI and SSI back payments. Care for those months covered by the back payment will be charged to me* or my* responsible party.

If I* will be living in an apartment, I authorize disclosure to the landlord that I* am a client of the Department of Mental Health.

I understand that licensed residential facilities in the State of Missouri sometimes house individuals who are required to register as sexual offenders and/or individuals who were charged with sexual offenses but were not convicted because they were determined by the court to permanently lack the capacity to understand the charges against them or to assist in their defense as set out in section 552.020, RSMo. Therefore, it is possible that the facility to which I* am being referred, or will be referred in the future, houses registered offenders or individuals not convicted on sexual offense charges due to a lack of capacity finding under section 552.020, RSMo. This notification is provided in compliance with section 630.127, RSMo, and Department Operating Regulation Number 4.720.

*For a guardian or a parent of a minor client, the words “I,” “me,” “my,” or “mine” refer to the client where indicated.

Signature of client, guardian, or parent of minor client:	Witness:
Date:	Witness: