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 DISTRICT	NO. IN HOUSEHOLD	IF VETERAN, DATE 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	Worker 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
				$ 0.00					$ 0.00
				$ 0.00					$ 0.00
				$ 0.00					$ 0.00
				$ 0.00					$ 0.00
				$ 0.00					$ 0.00
Less: Extraordinary Medical Expenses				$ 0.00	**Less: Extraordinary Medical Expenses**				$ 0.00
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

(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	Veteran? NO
					☐	☐
					☐	☐

Section 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
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 _____.

OR

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 Refuses to sign this notice in my presence:	WITNESS	DATE
OR This notice was sent by mail on	DATE	SIGNATURE

OZARK CENTER
An Affiliate of Freeman Health System

CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

I wish to seek treatment from Ozark Center for professional services, regardless of location of service provided which may include, but is not limited to Ozark Center facilities, Freeman Health System, Ozark Tri-County Health Care Consortium or my current school (hereinafter referred to as 'Ozark'). I authorize any location of Ozark to contact me by telephone and/or text to discuss my care or care options.

I understand that Ozark is approved to train medical students, residents, nurses and allied health students. I also understand students and residents may observe or participate in my care under the supervision of a qualified physician and/or instructor of the staff of Ozark. I agree to such involvement, unless I notify Ozark to the contrary in writing.

I understand that all information pertaining to me compiled by Ozark or in custody of Ozark is considered confidential and will not be released without my specific written authorizations. Exceptions to this are:

1. If my treatment requires admission in any of the above facilities, free exchange of information will take place in order to aid in my treatment.
2. If disclosure of information is required by law: e.g. court subpoena, bench warrant.
3. If a medical and/or psychological emergency arises in which there exists an immediate danger to my life or the life or lives of others.

I consent to the taking of my photograph for the limited purpose of identification and staff education or training.

A photocopy of this authorization is considered as valid as the original.

AGREEMENT FOR FINANCIAL RESPONSIBILITY

I request that payment of Medicare, Medicaid, State Purchase of Services, Medigap and/or Private Insurance, Primary and Secondary benefits be made on my behalf to Ozark Center for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration or the Entitlement/Insurance Benefits representatives and/or their agents any information needed to determine these benefits for the benefits payable for related services.

I understand and agree that claims for reimbursement filed on my behalf with third party interests such as private insurance, Medicare, Medicaid, State Purchase of Services and/or others, does not release me from the financial obligations which I have hereby assumed. I also agree that in any circumstance when a third party does not provide full reimbursement for services rendered, for whatever reason, I shall remain responsible for the resulting balance, which may include deductible amounts, co-insurance and/or but not limited to non-covered services, provided such responsibility is not contrary to existing laws, rules or regulations which may apply. If delinquent, I agree to pay all costs of collection, including court costs, reasonable attorney fees and/or collection agency fees. I understand that Ozark does not assess an interest charge on open accounts, so the annual interest rate is 0%.

Client Name: DOB: OC #:
07.70000.09592.ADMS.0014.0119 White Copy: Chart, Yellow copy: Client

I understand that if an ambulance is called on my behalf that I am responsible for payment for this service and that Ozark is not financially responsible for covering the ambulance service, or any subsequent medical or psychiatric treatment.

I, the undersigned, do [ ] or do not [ ] authorize the use of facsimile to provide information to my provider of coverage.

_____ _____

(CLIENT NAME – PRINT) (CLIENT DATE OF BIRTH)

_____

CLIENT OZARK CENTER NUMBER

_____ _____

CLIENT/RESPONSIBLE PARTY/GUARDIAN SIGNATURE (RELATIONSHIP TO CLIENT)

_____ _____

WITNESS SIGNATURE DATE

OZARK CENTER
An Affiliate of Freeman Health System
CLIENT RIGHTS AND RESPONSIBILITIES

RIGHTS

I have read and/or had explained to me the following list of Client Rights. I understand that I am entitled to the following rights and privileges without limitations:

A. To humane care and treatment;
B. To the extent that the facilities, equipment and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice;
C. To safe and clean housing;
D. To receive prompt evaluation, care and treatment, habilitation or rehabilitation;
E. To have my treatment, habilitation, or rehabilitation plan explained to me;
F. To be treated with respect and dignity as a human being in an age appropriate manner;
G. To be the subject of an experiment or research only with my informed and written consent or the consent of the person legally authorized to act, and have the right to withdraw from research at any time;
H. To have an examination by a private, licensed practitioner at my own expense;
I. To be evaluated and cared for in the least restrictive place;
J. To refuse hazardous treatment or surgery unless ordered by a court or by consent of a parent/guardian;
K. To request and have a second opinion before hazardous treatment or irreversible surgery, except in emergencies;
L. To have records kept confidential in accordance with state and federal laws and regulations. To restrict the use or disclosure of protected health information. To review and receive a copy my health information (restrictions may apply). To request an amendment to my health information. To receive an account of the disclosure of my health information;
M. Unless otherwise stated by law, I have the same legal rights and responsibilities as any other citizen;
N. To not be denied admission or services because of race, gender identity, creed, sex, sexual orientation, religion, marital status, national origin, disability, age, veteran status, and any other classification protected by law; and,
O. To be free from abuse, neglect, corporal punishment and other mistreatment such as humiliation, threats, exploitation or retaliation.
P. I have received a copy of the Ozark Center Notice of Privacy Practices.

These rights apply to residential settings only:

A. To have private visits from my lawyer, doctor or clergyman at reasonable times;
B. To correspond by sealed mail with officials of the Department of Mental Health, my lawyer, or a court;
C. To attend or not attend religious services;
D. To have nourishing, well-balanced meals; and,
E. To not work unless part of treatment.

OZARK CENTER
An Affiliate of Freeman Health System
CLIENT RIGHTS AND RESPONSIBILITIES

I understand that I should contact Ozark Center immediately if I believe that my rights have been violated. If I am unable to contact Ozark Center immediately, I agree to contact Ozark Center within thirty (30) days.

RESPONSIBILITIES

As a client, you have the responsibility:

A. For your actions and the consequences. Should you refuse treatment, not follow your treatment plan, or leave the facilities against professional advice;
B. I agree that I will reimburse the Ozark Center for services rendered in accordance with the fees and terms agreed to between me and Ozark Center;
C. To provide accurate and complete information concerning your current health, complaints, past history, and all matters that may affect your treatment;
D. For communicating to your provider whether or not you understand the course of your treatment and what is expected of you;
E. For following the treatment plan established with you, including instructions from all mental health professionals;
F. To inform staff that you wish to change your treatment plan;
G. For being considerate of the rights of other clients and personnel; and,
H. For following all facilities policies and procedures.

OZARK CENTER IS NOT RESPONSIBLE FOR PERSONAL VALUABLES.

_____
Client Signature Date

_____
Witness Signature Date