Effective Date:_____ **Admission Status**: ☐ Pre-Registered ☐ Registered ☐ Admit ☐ Update

Provider #:_____ Name:_____ Unit #:_____ Sub-Unit#:_____

CLIENT IDENTIFYING INFORMATION

Name: First:_____ Middle:_____ Last:_____

Suffix:_____

Address:_____ Home Ph:_____

City/State/Zip:_____ Cell Ph:_____

Employer:_____ Work:_____

SSN:_____ If blank, reason SSN not provided:_____

DOB:_____ Gross Monthly Income: $_____

# of children living with you:_____ # in household:_____

Email:_____

If email is provided, you are consenting to electronic communications with ReDiscover at the email address above & understand and accept the risks involved. List of risks is available on ReDiscover's website or upon request.

Please circle one item in each category

Gender: Male Female Male to Female Female to Male Other

Marital Status: Never Married Married Widow Divorce Separated Common Law

Race: White Black/African American Asian American Indian/Alaskan Native Bi-Racial
Native Hawaiian/Pacific Islander Other:_____

Hispanic Origin: Puerto Rican Cuban Mexican Other:_____

Employment Status: Un-employed Part time Full time Disabled Retired Homemaker Student

Occupation: Clerical Craftsman Laborer Managers Military Operatives/Mech Professional Sales
Service / household Other:_____

Living Arrangements: Living w/both parents Living w/single parent Living w/other _____ Living alone
Nursing Home Foster Home Transitional/Supported living Jail/Correctional facility Homeless RCF

Veteran: Yes No

Education: Kindergarten 1st-12th Grade ____ (indicate grade) GED College (# of years)_____ No Academic

Hearing Status: Normal Hard of hearing Deaf Unknown

Preferred Language: English Spanish Other:_____

Referred by: Family Friend Self Former client Medical Dr. Hospital/ER School Dept of Social Services
Court/Law Enforcement Probation/Parole Drug Court MH Court Internet/Other advertising Insurance Co.
Other:_____

Legal Status: Does not apply Awaiting Disposition Probation Parole
If on P & P, Officer name:_____
Office Location & Ph#:_____

Client Name:_____ MR#:_____

ReDiscover

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The questions in the following 2 boxes refer to the **Insured Person's** information.

Primary Insurance ☐ self ☐ parent ☐ spouse ☐ guardian DOB:_____

Name:_____ SSN:_____
Last First M.I.

Address:_____ Home Ph _____

Employer:_____ Work Ph: _____

Insurance Co:_____ Plan Name:_____

I.D. #:_____ Group#_____

Secondary Insurance ☐ self ☐ parent ☐ spouse ☐ guardian DOB:_____

Name:_____ SSN:_____
Last First M.I.

Address:_____ Home Ph _____

Employer:_____ Work Ph: _____

Insurance Co:_____ Plan Name:_____

I.D. #_____ Group#_____

Alias(es)

Last Name:_____ First:_____ Middle:_____

Last Name:_____ First:_____ Middle:_____

Last Name:_____ First:_____ Middle:_____

Emergency Contact

Name:_____ Relationship:_____ Ph#:_____

Name:_____ Relationship:_____ Ph#:_____

Advance Directive Statement: I have an Advance Healthcare Directive: ☐ Yes ☐ No ☐ N/A ☐ Unknown

Responsible Party

Name:_____ Relationship:_____ Ph#:_____

Address:_____ Cell:_____

_____

Employer:_____ Wk #:_____

Family Members Currently in Service

Is this person in your care?

Name:_____ Relationship:_____ ☐ Yes ☐ No ☐ Unknown

Name:_____ Relationship:_____ ☐ Yes ☐ No ☐ Unknown

Name:_____ Relationship:_____ ☐ Yes ☐ No ☐ Unknown

The following will be completed by staff:

PAYORS: (1) (2) (3) (4) (5) (6)
(7) (8) DMH Co-pay: $_____

Diagnosis: Provide DSM diagnosis for Axis I, II, IV and V; Axis III is coded from ICD 9 M for physical health:

Axis I Axis II Axis III Axis IV Axis V

Primary:_____

Secondary:_____

Client's Name:_____ MR #:_____

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Initials

I understand it is my responsibility to notify *ReDiscover* of any change in my status such as: _____

a) Insurance coverage
b) Medicaid or Medicare coverage
c) Income and/or employment
d) address, phone number, and/or email

I authorize my payor source(s) to pay *ReDiscover* any benefits due for services rendered and understand that ReDiscover will release my information as necessary to process my claims. _____

I understand I am financially responsible for any charges not covered by my payor(s) including co-pays, deductibles, or co-insurance as determined by my Insurance Plans. _____

I understand if I do not keep my account current, *ReDiscover* has the right to suspend my treatment until my account is made current. I further understand that if I choose to discontinue treatment, I am still responsible for the full balance due, and that my unpaid balance may be referred to a collection agency. _____

I acknowledge *ReDiscover* has the right to release any information acquired during my assessment and treatment (including alcohol/drug use or HIV testing or status, if applicable) that is necessary to process payment for my services. _____

I understand that my information and treatment records are strictly confidential, and will only be released with my written permission or as specified by law. _____

I authorize *ReDiscover* to provide the treatment deemed necessary to improve the overall well being of the client named below. _____

I understand that services may be provided via telehealth and I consent to receiving services by this method, if necessary. I understand that I have the right to be informed of all participants present during my service session and at my request, I may ask that any participant be excluded from the session. I understand that telehealth services will not be recorded (audio, video, and/or photographed) without my express written consent. _____

I acknowledge receiving a copy of *ReDiscover's* Client Handbook which includes: _____

a) My Rights and Responsibilities as a client.
b) Notice of Privacy Practices
c) the process for filing/resolving concerns/ grievances

I have an Advance Healthcare Directive: ☐ Yes ☐ No ☐ N/A ☐ Unknown _____

☐ Per COVID19 protocols, signature will be obtained later. Verbal authorization received by _____ (Name of Staff)

_____ Date: _____
Client or Authorized Representative Signature

_____ Date: _____
Witness Signature

DOB: _____

Client Name _____ MR # _____

ReDiscover

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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 _____.

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 re-determined annually or at any time it is known that _____ 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.

☐ Per COVID19 protocols, signature will be obtained later. Verbal authorization received by

(Name of Staff)

SIGNATURE OF CLIENT OR FINANCIALLY RESPONSIBLE PERSON	WITNESS	DATE
X		
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

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	VETERAN? 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

☐ Per COVID19 protocols, signature will be obtained later. Verbal authorization received by

(Name of Staff)

(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