

CLIENT AGREEMENT

I have not supplied documentation of household income. I declare my household income is within Missouri Screen for Life program’s present income guidelines. _____ **(If applicable, please initial)**

I have received the income guidelines and I qualify for Missouri Screen for Life.

I understand that the Missouri Screen for Life services will be available to me at no cost.

I understand that my health is my responsibility. I am responsible for keeping my appointments.

I understand that persons associated with Missouri Screen for Life may contact me in receiving medical recommended services.

I understand that no test is 100% accurate.

As a client receiving services funded by Missouri Screen for Life Program, I acknowledge that I have been given a copy of the Missouri Department of Health and Senior Services Notice of Privacy Policies and have been told where I can obtain any subsequent revisions to the Notice.

Signature of Client/Parent/Guardian/
Durable Power of Attorney for Health Care (DPOA-HC)

_____/_____/_____
DATE

If signature other than that of client, please print name and indicate relationship:

DHSS Staff/Volunteer Signature
(if present when Notice is provided)

DATE