

**MENTAL HEALTH ASSOCIATION, INC
SPRINGFIELD DMR RESPITE**

CHARGES FOR CARE AGREEMENT

Individual: _____ DOB: _____

SSN: _____ - _____ - _____

Charges for care while you are living at the Springfield Respite Program are calculated at 75% of your monthly income. Payment is expected upon admission and then on the first of each month thereafter. Upon discharge, any monies that are owed to you will be sent to you at your discharge address.

Charges for entire month of: _____

Source of Income: _____

Total Monthly Income: \$ _____

Charges for Care: \$ _____ (income x 75%)

Total due: \$ _____

Charges for partial month: From _____ **to** _____

Monthly income divided by 30 days= \$ _____/day

Number of days at respite: _____

Daily rent multiplied by # of days in respite= \$ _____ due for month

Total due: \$ _____

Mail statements to: _____

Submitted to fiscal on: _____

Submitted by: _____