Notice of deposit statement

A deposit equivalent to four (4) week’s service charge will be expected upon execution of the Service Agreement before the start of services. **If you request a decrease/increase in services, the deposit will be increased proportionately.**

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| --- |
| Start date, Name & Address of Care Recipient |
|  |

|  |
| --- |
| Notice Date |
|  |

**THIS SERVICE START DATE \_\_**\_\_\_\_\_\_\_**\_.** The deposit will be held by the agency without interest for the duration of services. Any unused portion of that amount will be promptly refunded to the recipient upon termination of services.

|  |  |  |  |
| --- | --- | --- | --- |
| **#** | **Total number of hours Requested** | **Rate of Services** | **Weekly Total** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| Total Deposit Required\* | | |  |

Naomie Homme

Naomie Homme

Billing Administrator

(866) 915-7837 ext. 718

IF YOU DO NOT AGREE WITH INFORMATION ON THIS NOTICE, YOU CAN ASK FOR A CONFERENCE.

CC: Administration

Client File