**Notice of deposit □** decrease/ **□** increase

A deposit equivalent to FOUR (4) week’s service charge will be expected upon execution of the Service Agreement before the change of services.

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| --- |
| **Start date, Name & Address of Care Recipient** |
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|  |
| **Notice Date** |
|  |

**If you request a decrease/ increase in services, the deposit will be decreased/ increased proportionately. THIS CHANGE EFFECTIVE: \_\_\_\_\_\_\_\_\_** 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.

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| **DEPOSIT ACCOUNT BALANCE** |
| **# Weeks** | **Balance Total Number of Hours**  | **Introductory Rate of Services** | **Total** |
|  |  |  |  |

|  |
| --- |
| **NEW DEPOSIT ACCOUNT**  |
| **# Weeks** | ***Requested*** **Total Number of Hours**  | **Introductory Rate** Decrease/Increase **of Services** | **Total** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Total |  |  |  |

|  |
| --- |
| **NEW *REQUIRED* DEPOSIT ACCOUNT**  |
| **Total Number of Account Hours**  | **Introductory Rate of Services** | **Deposit Account** **Balance** | ***Requested* Total Number of Hours** (Bal. Total Hours plus *Requested Total Hours*) | **Rate** **Decrease/ Increase of Services** | **New Deposit Account Balance** | ***Required* Deposit Account Balance Total**(Deposit Account Bal. minus New Deposit Account Balance)  |
|  |  |  |  |  |  |  |

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