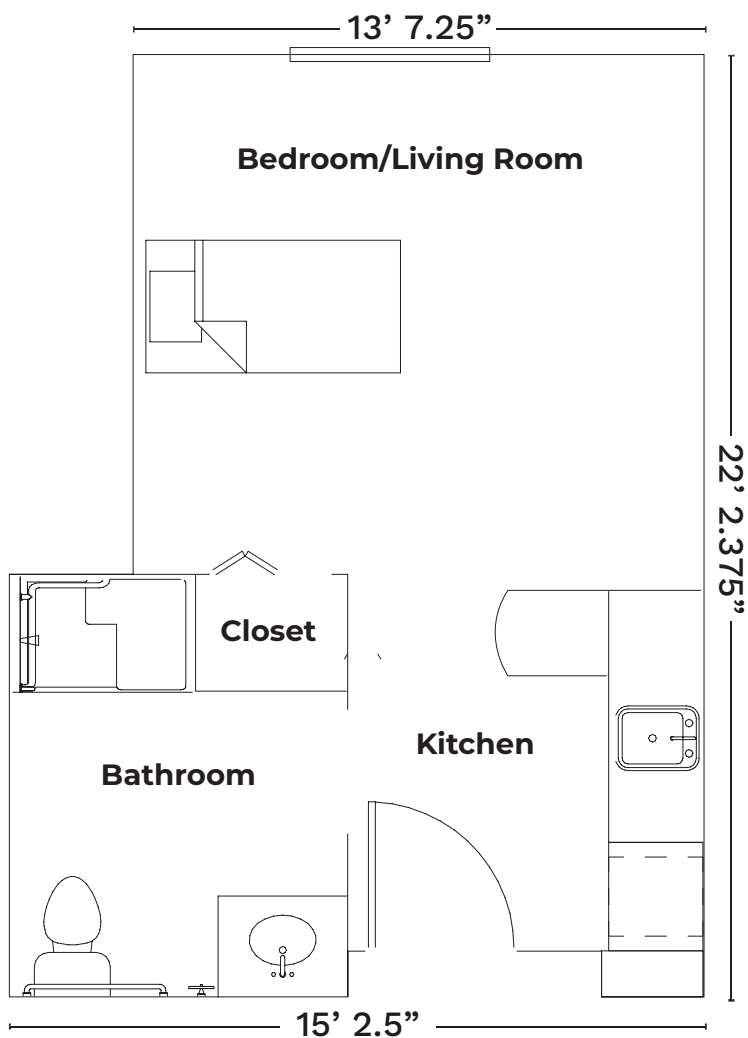


# Studio

345-348 SQ. FT.



DATE \_\_\_\_\_ RESIDENCE NUMBER \_\_\_\_\_ PREPARED BY \_\_\_\_\_

ONE-TIME COMMUNITY FEE	MONTHLY FEE	SECOND-PERSON FEE	ESTIMATED LEVEL OF CARE*
\$ _____	\$ _____	\$ _____	\$ _____

OTHER	TOTAL MONTHLY FEE
\$ _____	\$ _____

\*To be determined based upon clinical assessment