
445 A Willard Ave
Newington, CT 06111

**FINANCIAL RESPONSIBILITY**

Participant's name: _____

Address: _____

Telephone Number: (_____) _____

**Financial Responsible Party:**

_____ Private Pay

_____ Long term Health Insurance (Company and policy #_____)

**Private Pay Financial Responsible Party:**

Name: _____ Home# _____

Work # _____ Cell # _____

Address to be billed: _____

_____

Relationship to participant: _____

I agree to pay for the services of Family Adult Day Care at the price, in force at the week enrolled. I agree that I will be billed in advance and agree to pay by the Friday prior to the specified week.

**Checks will be made payable to Family Adult Day Care**

I understand that I will **not** be billed for the days that I am absent from the program, including; illness or leave of absence

Signature _____ Date _____