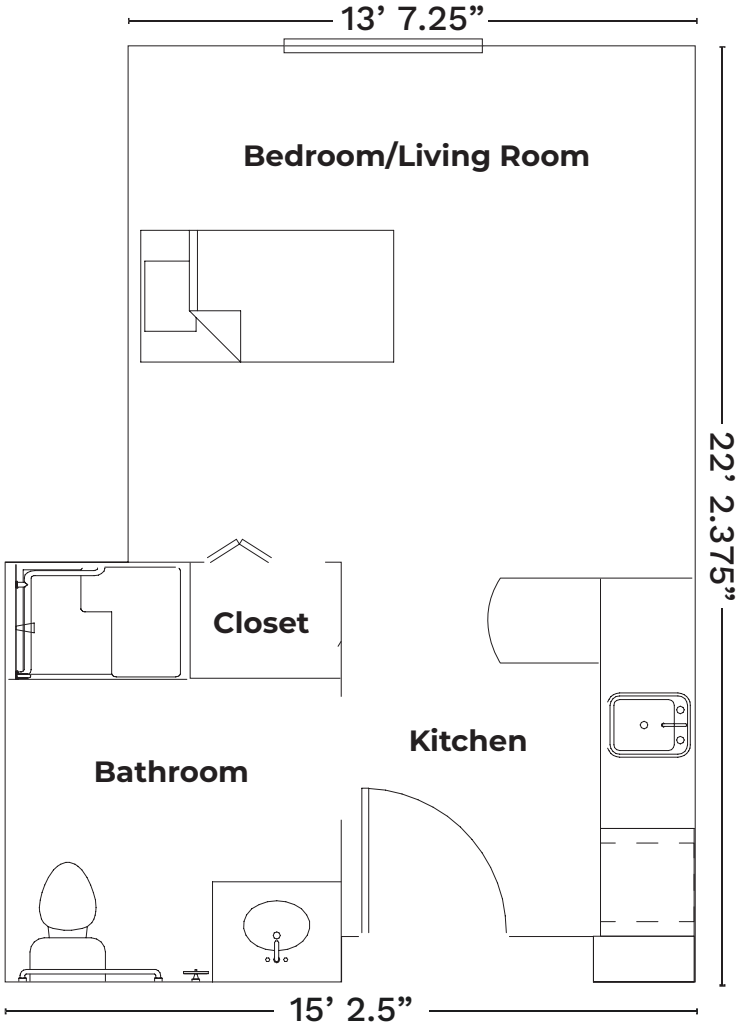
# Studio

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

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