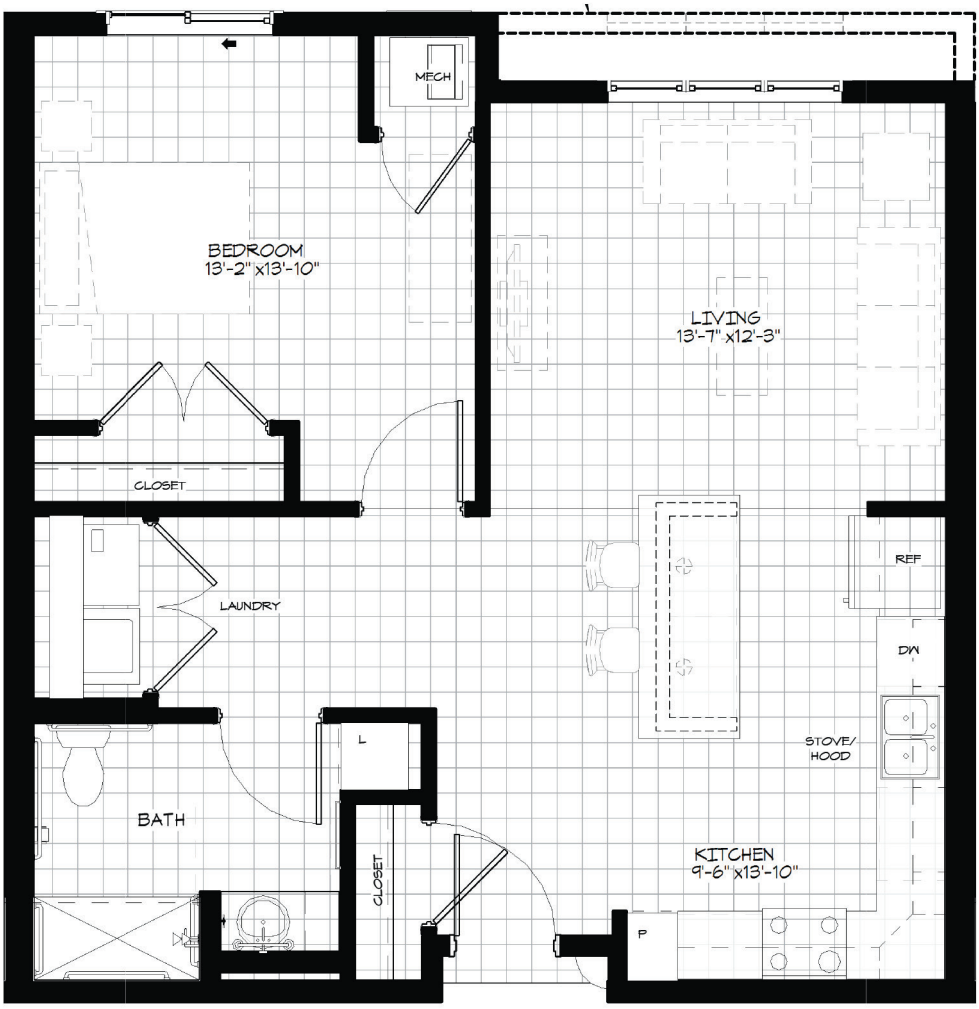
Clear Spring

1 BEDROOM · 764 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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