

Interior AIDS Association
Project Special Delivery
Payment Contract

I understand that PSD's treatment fees are as follows:

Intake:	\$400			
	0-3 months	3-12 months	12-18 months	18+ months
Monthly Fees	\$750	\$575	\$450	\$425
Weekly Fees	\$200	\$155	\$125	\$120

Please initial the box next to each paragraph to confirm that you have read and understand each statement.

PSD has a sliding fee scale. Based on your family income and the number of members in your family, the payments range from a minimum of \$175 per month to full payment as charged. Fees are due on the day of admission (prorated) and then by the 5th day of each month if paid monthly. Fees paid weekly are considered late on Tuesday of each week. Any past-due fees must be paid prior to being readmitted to the program. Payment must be made in cash, money order, or cashiers check: Personal Checks are NOT accepted.

I understand that once I am accepted into treatment, treatment and intake fees are not refundable if I do not appear or do not complete treatment services.

I have been advised of applicable federal and state public assistance programs (Medicaid).

Based on the information I provided in the attached PSD financial questionnaire, I agree to pay PSD \$_____ on or before my admission date for intake and treatment, or I will deliver a Medicaid Coupon for the month of _____ prior to my admission date.

I agree to pay PSD \$ _____ per month or \$_____ per week for continuing treatment services at PSD.

I understand that if I fail to pay my treatment fees on time, I may make a payment plan with the Program Director. I also understand that if I fail to make a plan or fail to follow that plan I may be subject to administrative detoxification.

I have received a copy of this Payment Contract

Consumer Name (Print): _____ PSD# _____

Signature: _____ Date: _____

Program Director: _____ Date: _____