

**DAYBREAK ADULT DAY SERVICES, INC.
PARTICIPANT FEE DETERMINATION**

PARTICIPANT NAME: _____

SOCIAL SECURITY NUMBER: _____

I am not applying for financial assistance (Please skip to signature below. You DO NOT need to disclose financial information)

I am applying for financial assistance. (Please complete information below and remit with verification documents)

NUMBER OF PERSONS IN FAMILY: (CHECK ALL THAT APPLY)
 ___ SELF ___ SPOUSE ___ DEPENDANT CHILDREN (specify number)

GROSS INCOME (Please specify if monthly or yearly)

	SELF	SPOUSE
Social Security		
SSI/Disability		
Pension/Retirement		
Annuities		
Dividends/Interest		
Other Income		
TOTAL INCOME		

TOTAL HOUSEHOLD INCOME: _____ per month _____ per year

VERIFICATION MUST BE ATTACHED (IE: SOCIAL SECURITY STATEMENT, PENSION STATEMENT OR 2016 TAXES)

SIGNATURE

DATE

FOR OFFICE USE ONLY				
BILLING INFORMATION			START DATE: ____/____/20__	
<input type="checkbox"/> Private	<input type="checkbox"/> OHS	<input type="checkbox"/> VA	<input type="checkbox"/> MA	<input type="checkbox"/> Other (specify)
CACFP CODE:		DAILY RATE:		
Days: <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F			Transportation: Vans <input type="checkbox"/> Client <input type="checkbox"/>	
DATE RECEIVED:		RECEIVED BY :		