SC DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

PAST DUE PAYMENT AGREEMENT

ACCOUNT NAME:_____

ACCOUNT NUMBER(S):_____

I, _____(Responsible Party), recipient of care and maintenance bills for _____ (person's name), hereby agree to the following terms for payment of _____ _____ (person's name) past due care and maintenance charges. I will pay $_____(amount) per month for _____ (number of months) with the final payment of $_____ (final payment amount) being due _____(mm/dd/yy). I understand this is to be paid in addition to normal monthly care and maintenance charges.

The first payment is due _____(mm/dd/yy). Each subsequent monthly payment is due by the 20th day of each month until paid in full. I understand that if I fail to make payments of the additional amounts stated above, the full amount of the outstanding balance must be paid in full upon receipt of notice that this agreement is in default. (Default occurs when a payment is not received within 30 days of the due date.)

_____ Date:_____
Parent/Responsible Party

_____ Date:_____
Regional Claims and Collection Officer

_____ Date:_____
Regional Facility Administrator

_____ Date:_____
Chairman, Accounts Receivable Review Committee