5130 Rose Hill Blvd.
Holly, MI 48442-9507
Phone: 248.531.2405
Fax: 248.634.7754
rosehillcenter.org

Financial Responsibility Form

Applicant's Name: _____

I, the undersigned, will personally pay the full Rose Hill fee for (please select only one):

- ☐ Residential Rehabilitation Program $400 per day
- ☐ Co-Occuring Residential Rehabilitation Program $450 per day
- ☐ I have applied for financial assistance and agree to pay a portion of the daily rate as determined by the Rose Hill Financial Assistance Committee.

I agree to be financially responsible for all expenses incurred by the resident while at Rose Hill Center, including any medical expenses not covered by insurance. I understand that the daily rate at Rose Hill Center includes room and board, psychiatric services, and the rehabilitation program.

Fees are subject to change, and a 30-day notice will be given before any changes become effective. Rose Hill typically increases fees on January 1 of each year, but other increases may be required from time to time.

I understand that, upon admission, TWO MONTHS SECURITY DEPOSIT WILL BE REQUIRED and will be held until discharge. The financially responsible person(s) will be required to sign a Financial Guarantee form stating that they will not:

a) Seek Rose Hill Center Financial Assistance during the first four months following admission

b) Seek community mental health funding, after admission, for services provided by Rose Hill Center

Signature: _____

Print name: _____

Relation to applicant: _____

Address: _____

City/State/Zip _____

Home Phone _____ Business Phone _____