Iowa Department of Human Services

Voluntary Contribution Agreement

1. I , agree to contribute $ monthly toward the care of , a Medicaid resident of , a health care facility located in . This contribution will be furnished to the facility no later than the day of each month. I understand that this contribution is completely voluntary. I am making it with the understanding that I may terminate or change the amount of contribution at any time I so desire. If I decide to terminate or change the amount of my contribution, I will notify the facility of my intentions.

Name	Date
Address	

2. I understand that the voluntary contribution stated in paragraph 1 is to be considered as financial participation toward the basic cost of the care of the resident designated and that if such contribution ceases, or changes in amount, the local office of the Department of Human Services will be promptly notified.

Administrator or Representative	Date
Facility	
Address	

3. I understand that the amount of voluntary contribution stated in paragraph 1 is to be considered as financial participation toward the care of the resident named until notified otherwise. Upon notification of any change in the amount of contribution, such information will be promptly forwarded to the Quality Assurance Section of the Department of Human Services and, if applicable, a new letter of Agreement will be initiated.

Department of Human Services Representative	Date
Local Office	