Notice of Payment Plan

Date: _____

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

For Services Rendered To:

BHS MIS Case Number:

UMDAP AMOUNT $_____Contract Year _____

This payment plan will consist of ____consecutive monthly payments of $_____each.

The first monthly payment is due _____ and the final payment is due _____.

All payments shall be sent to:

County of San Diego
BHS Billing Unit
P.O. Box 129153
San Diego, CA 92112-9153
(619) 338-2612

In the event of non-payment, your account may be referred to the County of San Diego Office of Revenue and Recovery for additional collection activities.

By signing below you are acknowledging that you understand that you owe for services provided.

_____ _____
Responsible Party Signature Program Staff Signature

_____ _____
Date Date