

**Mt. Diablo Center for Adult Day Health Care
Sponsor a Participant**

Your Name _____
Street Address _____
City, State Zip _____
Telephone () _____ Email: _____

One day of Adult Day Health Care is reimbursed by Medi-Cal at a rate of \$76.50.

_____ One year of support: \$76.50 per month deduction from your VISA or MasterCard.
Annual total: \$918

_____ One year of support: Check in the amount of \$918 enclosed.

_____ \$500

_____ \$200

_____ \$100

_____ Other _____

Visa or MasterCard # _____ Exp. Date _____

Name as it appears on the card _____

Date of the month you want card debited for monthly contributions _____

Signature of card holder _____ 3-digit security code _____

Mail to:

**Sponsor a Participant Scholarship Fund
Mt. Diablo Center for Adult Day Health Care
490 Golf Club Road, Pleasant Hill, CA 94523**

Phone: (925) 682-6330 – Debbie Toth

Thank you. Your contribution is tax deductible. RSNC Tax ID: 94-2822559.