Maunalani Nursing
and Rehabilitation Center

Agreement for Cable Services

Resident's Name: _____

Room and bed number: _____

Name of Financial Responsible Party: _____

- I request that cable service be made available for the above-named resident.
- I understand that I am responsible for the daily charge of $1.25 for basic cable services (Spectrum TV select channels) which will be billed to me in my monthly bills.
- I will bring in my own TV (no larger than 32") for my room.
- I will be responsible to pay for any on-demand or pay-per-view shows that I purchase.
- I will return the cable TV receiver upon my discontinuation of service or my discharge from Maunalani**.**

Resident Name:_____ Date: _____

Resident Signature: _____

Or:

POA Name:_____ Date: _____

POA Signature: _____

(Internal use only)
Cable TV Receiver Serial Number:_____