# DISCLOSURE FOR HOUSING WITH SERVICES ESTABLISHMENTS

State Form 49028 (R3 / 7-11)

Date received stamp (*month, day, year*)

The Disclosure for Housing with Services Establishments form is to be submitted to comply with IC 12-10-15. All sections, except Section 8, Optional Information, shall be fully completed. Section 8 is optional and provides information that you may wish to answer for potential residents who may use this form when looking for services.

A copy of the contract to be executed between the Housing with Services Establishment and the resident is the ONLY attachment that will be accepted in addition to the disclosure form. Therefore, it is important to concisely answer the questions on the form.

Indicate whether this is an original, update, or a renewal and enter date:

☐ Original Year ________________________ ☐ Update Year ________________________ ☐ Renewal Year ________________________

## SECTION 1 - ESTABLISHMENT INFORMATION

| Name of facility | | Facility Employer Identification Number (EIN) |
|---|---|---|
| On site manager's name | | |
| Address line 1 (*number and street*) | | |
| Address line 2 (*number and street*) | | |
| City | County | ZIP code |
| Telephone number ( ) | Fax number ( ) | E-mail address |

Capacity (*number of apartments*)

Is the facility licensed as a residential care facility by the Indiana State Department of Health? ☐ Yes ☐ No — If Yes, license number

Does the facility participate in the Residential Care Assistance Program (RBA/ARCH)? ☐ Yes ☐ No — If Yes, enter the 4 digit ID

Is the facility an Assisted Living Medicaid Waiver provider? ☐ Yes ☐ No

Is your facility structure (*select one*):

- ☐ freestanding?
- ☐ part of a campus or complex? (*select all that apply*)
  - ☐ part of an independent apartment complex?
  - ☐ part of a nursing facility?
  - ☐ part of an independent living building?
  - ☐ part of a hospital?
  - ☐ part of a continuing care facility?
  - ☐ other: ____________________________

## SECTION 2 - OWNERSHIP / TYPE OF BUSINESS INFORMATION

| Name of owner/company | | |
|---|---|---|
| DBA | | |
| Address line 1 (*number and street*) | | |
| Address line 2 (*number and street*) | | |
| City | State | ZIP code |
| Telephone number ( ) | Fax number ( ) | E-mail address |

| Name of managing agent (*if not owner*) | | |
|---|---|---|
| Address line 1 (*number and street*) | | |
| Address line 2 (*number and street*) | | |
| City | State | ZIP code |
| Telephone number ( ) | Fax number ( ) | E-mail address |

Type of business (*select one*):

☐ For Profit ☐ Not For Profit ☐ Government ☐ Other (*please indicate*)

Business ownership (*select one*):

☐ Sole Owner ☐ Partnership ☐ Corporation ☐ Other (*please indicate*)

Month of the year that begins your fiscal (*accounting*) year?

## SECTION 3 - CORPORATE OFFICERS

| Name | | |
|---|---|---|
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |

| Name | | |
|---|---|---|
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |

| Name | | |
|---|---|---|
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |

| Name | | |
|---|---|---|
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |

## SECTION 4 - MEMBERS OF GOVERNING BODY/ CORPORATE DIRECTORS

| Name | | |
|---|---|---|
| Title | | Telephone number: ( ) |
| Address line 1 *(number and street)* | | |
| City | State: | ZIP code: |

| Name | | |
|---|---|---|
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |

| Name | | |
|---|---|---|
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |

| Name | | |
|---|---|---|
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |

| Name | | |
|---|---|---|
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |

| Name | | |
|---|---|---|
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |

## SECTION 4 - MEMBERS OF GOVERNING BODY/ CORPORATE DIRECTORS (*continued*)

| Name | | |
|---|---|---|
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |
| Name | | |
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |
| Name | | |
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |
| Name | | |
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |
| Name | | |
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |
| Name | | |
| Title | | Telephone number ( ) |
| Address line 1 *(number and street)* | | |
| City | State | ZIP code |

## SECTION 5 - BASE RATE

Normal length of lease (*contract*):

☐ 1 month ☐ 3 months ☐ 6 months ☐ 1 year

☐ Other:

MONTHLY Per Person Base Rate Ranges for all that apply:

(*Note: If you convert a daily rate to a monthly rate please multiply your daily rate by 365 and then divide by 12.*)

| | From | To | Semi-Private Occupancy: | Kitchenette: |
|---|---|---|---|---|
| Studio | From: $ ______ | To: $ ______ | ☐ Yes ☐ No | ☐ Yes ☐ No ☐ Optional |
| One Bedroom | From: $ ______ | To: $ ______ | ☐ Yes ☐ No | ☐ Yes ☐ No ☐ Optional |
| Two Bedroom | From: $ ______ | To: $ ______ | ☐ Yes ☐ No | ☐ Yes ☐ No ☐ Optional |

☐ Additional fees may be required (*examples - admission fee, deposit fee, buy in fee, etc.*)

☐ Additional:______

## SECTION 6 - CONTRACT INFORMATION

What is the criteria and process used to determine who may continue to reside in your facility?

## SECTION 6 - CONTRACT INFORMATION (*continued*)

Can the contract be modified or terminated by the facility? ☐ Yes ☐ No If Yes, please explain under what conditions and the referral process.

Can the contract be modified or terminated by the resident? ☐ Yes ☐ No If Yes, please explain under what conditions and the referral process.

Outline the steps that should be taken by the resident to register a complaint and the process for resolving the complaints.

## SECTION 7 - SERVICES INCLUDED IN THE BASE RATE AND / OR AVAILABLE FOR AN ADDITIONAL FEE (*check all that apply*)

**MEALS:** Extra meal fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

| | | | | |
|---|---|---|---|---|
| Breakfast: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____ | To: $ ____ |
| Lunch: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____ | To: $ ____ |
| Dinner: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____ | To: $ ____ |
| Snacks: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____ | To: $ ____ |

☐ Comments:

**HOUSEKEEPING:** Extra housekeeping fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

| | | | | |
|---|---|---|---|---|
| | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____ | To: $ ____ |

☐ Comments:

**LAUNDRY:** Extra laundry fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

| | | | | |
|---|---|---|---|---|
| Bed/Bath Linens: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____ | To: $ ____ |
| Personal: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____ | To: $ ____ |

☐ Comments:

**PERSONAL ASSISTANCE:** Extra personal assistance fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

| | | | | |
|---|---|---|---|---|
| Dressing: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____ | To: $ ____ |
| Toileting: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____ | To: $ ____ |
| Transferring: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____ | To: $ ____ |
| Mobility: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____ | To: $ ____ |
| Bathing: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____ | To: $ ____ |
| Eating: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____ | To: $ ____ |

☐ Comments:

**SECTION 7 - SERVICES INCLUDED IN THE BASE RATE AND / OR AVAILABLE FOR AN ADDITIONAL FEE (*con't.*) (*check all that apply*)**

**BLOOD PRESSURE TAKEN:** Extra blood pressure fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

☐ Comments:

**EMERGENCY RESPONSE SYSTEM (ERS):** Extra "ERS" fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

☐ Comments:

**24-HOUR NURSING RESPONSE:** Extra 24 hr. fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

☐ Comments:

**LICENSED NURSING SERVICES AVAILABLE:** Extra fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

☐ Comments:

**MEDICATIONS:** Extra medication fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Reminders: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

Set-up: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

Dispensing: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

☐ Comments:

**ARRANGING OTHER MEDICAL SERVICES:** Extra medical fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

☐ Comments:

**ASSISTING WITH PERSONAL FUNDS:** Extra fund fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

☐ Comments:

**WANDER PROTECTION SYSTEM:** Extra wander fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

☐ Comments:

**ACTIVITIES:** Extra activity fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

Day Outings: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

In-House Activities: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

Event Tickets: ☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

☐ Comments:

## SECTION 7 - SERVICES INCLUDED IN THE BASE RATE AND / OR AVAILABLE FOR AN ADDITIONAL FEE (*con't.*) (*check all that apply*)

**TRANSPORTATION:** Extra transportation fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

| | | | | |
|---|---|---|---|---|
| Facility Scheduled: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____________ | To: $ ____________ |
| Unscheduled: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____________ | To: $ ____________ |

☐ Comments:

**UTILITIES:** Extra utilities fees are per: ☐ Month ☐ Bi-Week ☐ Week ☐ Day ☐ Other

| | | | | |
|---|---|---|---|---|
| Heating: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____________ | To: $ ____________ |
| Air Conditioning: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____________ | To: $ ____________ |
| Electricity: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____________ | To: $ ____________ |
| Water / Sewage: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____________ | To: $ ____________ |
| Local Phone: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____________ | To: $ ____________ |
| Cable TV: | ☐ Included | ☐ Not Included | ☐ Extra Fee, From: $ ____________ | To: $ ____________ |

☐ Comments:

**Services not listed on this form that are either included or available for an additional fee:**

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

Service:

☐ Included ☐ Not Included ☐ Extra Fee, From: $ ____________ To: $ ____________

**Other Wellness / Health Related Services:** ☐ Yes ☐ No If Yes, explain below:

## SECTION 8 - OPTIONAL INFORMATION

Do you offer wheelchair accessible units and / or common areas (*check all that apply*)?
☐ Units / Apartments ☐ Common Areas

Does each apartment have fire sprinklers? ☐ Yes ☐ No

Are pets allowed? ☐ Yes ☐ No If Yes, please describe any additional fees or special conditions below:

Do you have a nursing home / health care center at the same location? ☐ Yes ☐ No

Are rehabilitation services available on site? ☐ Yes ☐ No If Yes, please identify:

| SECTION 9 - INDIVIDUAL SUBMITTING THE DISCLOSURE / MAILING INSTRUCTIONS | | |
| --- | --- | --- |
| Name of individual completing the form | Title | |
| Company / Affiliation | | |
| Address (*number and street*) | | |
| City, state, ZIP code | | |
| Telephone number<br>( ) | Fax number<br>( ) | E-mail address |
| Verified by (*name*) | Title | |
| Verified by (*signature*) | | Date (*month, day, year*) |

Send the completed form to the following address: (*Please do not FAX*)

Disclosure for Housing with Services Establishments
FSSA Division of Aging
402 West Washington Street, Room W454, MS 21
Indianapolis, IN 46204

For question call: 1-888-673-0002

**DO NOT WRITE IN THIS SECTION**
**(*For Official Use Only*)**