



DISCLOSURE FOR HOUSING WITH SERVICES ESTABLISHMENTS

State Form 49028 (R / 9-05) / BAIS 0001

Date received stamp

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		
On site manager's name		
Address line 1		
Address line 2		
City	County	ZIP code
Telephone number ()	Fax number ()	E-Mail address
Capacity (number of apartments)		Is your facility structure (select one): <input type="checkbox"/> freestanding? <input type="checkbox"/> part of a campus or complex? (select all that apply) <input type="checkbox"/> part of an independent apartment complex? <input type="checkbox"/> part of a nursing facility? <input type="checkbox"/> part of an independent living building? <input type="checkbox"/> part of a hospital? <input type="checkbox"/> part of a continuing care facility? <input type="checkbox"/> other: _____
Is the facility licensed as a residential care facility by the Indiana State Department of Health? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, license number	
Does the facility participate in the Residential Care Assistance Program (RBA/ARCH)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, enter the 4 digit ID	
Is the facility an Assisted Living Medicaid Waiver provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION 2 - OWNERSHIP / TYPE OF BUSINESS INFORMATION

Name of owner/company		
DBA		
Address line 1		
Address line 2		
City	State	ZIP code
Telephone number ()	Fax number ()	E-Mail address
Name of managing agent (if not owner)		
Address line 1		
Address line 2		
City	State	ZIP code
Telephone number ()	Fax number ()	E-Mail address
Type of business (select one): <input type="checkbox"/> For Profit <input type="checkbox"/> Not For Profit <input type="checkbox"/> Government <input type="checkbox"/> Other (please indicate)		
Business ownership (select one): <input type="checkbox"/> Sole Owner <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Other (please indicate)		
Month of the year that begins your fiscal (accounting) year?		

SECTION 3 - CORPORATE OFFICERS

Name		
Title		Telephone number ()
Address line 1		
City	State	ZIP code
Name		
Title		Telephone number ()
Address line 1		
City	State	ZIP code
Name		
Title		Telephone number ()
Address line 1		
City	State	ZIP code
Name		
Title		Telephone number ()
Address line 1		
City	State	ZIP code

SECTION 4 - MEMBERS OF GOVERNING BODY/ CORPORATE DIRECTORS

Name		
Title		Telephone number: ()
Address line 1		
City	State:	ZIP code:
Name		
Title		Telephone number ()
Address line 1		
City	State	ZIP code
Name		
Title		Telephone number ()
Address line 1		
City	State	ZIP code
Name		
Title		Telephone number ()
Address line 1		
City	State	ZIP code
Name		
Title		Telephone number ()
Address line 1		
City	State	ZIP code

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

Name		
Title	Telephone number ()	
Address line 1		
City	State	ZIP code
Name		
Title	Telephone number ()	
Address line 1		
City	State	ZIP code
Name		
Title	Telephone number ()	
Address line 1		
City	State	ZIP code
Name		
Title	Telephone number ()	
Address line 1		
City	State	ZIP code
Name		
Title	Telephone number ()	
Address line 1		
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.)

	<u>Semi-Private Occupancy:</u>	<u>Kitchenette:</u>
Studio From: \$ _____ To: \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Optional
One Bedroom From: \$ _____ To: \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Optional
Two Bedroom From: \$ _____ To: \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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:	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Lunch:	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Dinner:	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Snacks:	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____

Comments:

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

<input type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
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Comments:

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

Bed/Bath Linens:	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Personal:	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____

Comments:

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

Dressing:	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Toileting:	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Transferring:	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Mobility:	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Bathing:	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> Extra Fee, From: \$ _____	To: \$ _____
Eating:	<input type="checkbox"/> Included	<input type="checkbox"/> Not Included	<input type="checkbox"/> 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 (<i>number and street</i>)		
City, state, ZIP code		
Telephone number ()	Fax number ()	E-Mail address
Verified by (<i>name</i>)		Title
Verified by (<i>signature</i>)		Date (<i>month, day, year</i>)
Send the completed form to the following address: (<i>Please do not FAX</i>)		
<p>MS 21 Assisted Living Disclosure Bureau of Aging and In-Home Services 402 West Washington Street Indianapolis, IN 46204</p> <p>(<i>For questions call: 317-234-0814</i>)</p>		

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