



"People  
helping people  
help  
themselves"

MICHAEL R. PENCE., GOVERNOR  
STATE OF INDIANA

**Division of Aging**  
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TO: Housing with Services Establishment Administrators

FROM: Patti Bailey  
Residential Care Assistance Program Coordinator  
Division of Aging

As stated in Indiana Code 12-10-15, effective September 1, 1999, any housing with services establishment must complete a "Disclosure for Housing with Services establishments" form. This includes any freestanding facilities and/or part of campus or complex (independent living, nursing facility, apartment complex, hospital and/or continuing care facility).

If a disclosure form is not submitted for meeting this definition "... the business cannot: (1) enter into or extend the term of the contract with an individual to reside in a housing with services establishment or (2) use the term "assisted living" to describe the housing with services establishments services and operations to the public..."

In addition to the initial filing of the disclosure forms it is required that annual updates be submitted. The updates should be submitted according to IC 12-10-15-10 ... section 10... each year after the initial year in which an operator has filed a disclosure document under section 7 of this chapter, the operator shall file with the director within four (4) months after the end of the operator's fiscal year an annual disclosure document.

This form can be accessed on the FSSA website. The web address is <http://www.in.gov/fssa>. If you have any questions regarding this law and/or completion of the disclosure form, please contact Patti Bailey at 317-234-2944 or [Patti.Bailey@fssa.in.gov](mailto:Patti.Bailey@fssa.in.gov).





# 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

**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.)*

	Semi-Private Occupancy:	Kitchenette:
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?

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**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.

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

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

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**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: \$ _____ |
|-----------------------------------|---------------------------------------|--|--------------|

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 (number and street)		
City, state, ZIP code		
Telephone number (     )	Fax number (     )	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)		
<p>Disclosure for Housing with Services Establishments FSSA Division of Aging 402 West Washington Street, Room W454, MS 21 Indianapolis, IN 46204</p> <p>For question call: 1-888-673-0002</p>		

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