DISCLOSURE FOR HOUSING WITH SERVICES ESTABLISHMENTS

State Form 49028 (R3 / 7-11)

Date received stamp (*month, day, year*)
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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 8 \ 15 \ 2024 ☐ Update Year \ \ ☐ Renewal Year \ \

SECTION 1 - ESTABLISHMENT INFORMATION

Name of facility	Facility Employer Identification Number (EIN)
HOLISTICARE HOMES	86-3034380

On site manager's name: NATALIE SANTIAGO

Address line 1 *(number and street)*: 57711 COUNTY ROAD 9

Address line 2 *(number and street)*:

City	County	ZIP code
ELKHART	Elkhart	46517

Telephone number	Fax number	E-mail address
(574) 360-8132	( )	SHELLEY@HOLISTICAREHOMES.COM

Capacity (*number of apartments*): 7

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: SHELLEY PILLADO

DBA: HOLISTICARE HOMES

Address line 1 *(number and street)*: 64180 BRICK CHURCH RD

Address line 2 *(number and street)*:

City	State	ZIP code
CASSOPOLIS	Michigan	49031

Telephone number	Fax number	E-mail address
(574) 360-8132	( )	SHELLEY@HOLISTICAREHOMES.COM

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?
1

SECTION 3 - CORPORATE OFFICERS

Name: SHELLEY PILLADO

Title: CEO | Telephone number: (574) 360-8132

Address line 1 *(number and street)*: 64180 BRICK CHURCH RD

City: CASSOPOLIS | State: Michigan | ZIP code: 49031

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: RAFAEL PILLADO

Title: VICE PRESIDENT | Telephone number: (574) 807-5430

Address line 1 *(number and street)*: 64180 BRICK CHURCH RD

City: CASSOPOLIS | State: Michigan | ZIP code: 49031

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

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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: $	☐ Yes ☐ No	☐ Yes ☐ No ☐ Optional
One Bedroom	From: $ 6,360.00	To: $ 10,060.00	☐ 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: DEPOSIT 500

SECTION 6 - CONTRACT INFORMATION

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

Each resident will receive an assessment upon admission to determine the appropriate level of care partnership prior to moving in. This assessment will allow us to develop a customized plan of care and train staff in specific strengths and needs. Every six months thereafter partnership needs assessment will be completed, or as conditions change. This assessment includes level of independence with BADLs, IADLs, mobility, safety, personal needs and wants and orientation.

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.

Your right to occupy your unit and live at the Facility and to receive other services is contingent upon timely payment of all due amounts. The facility has the right to terminate the contract for lack of payment

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

18.If you wish to leave the Facility you are required to give 30 days' notice of date you wish to terminate this Agreement. If you are leaving because of health emergency 30 days' notice is not required.

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

The resident should report their complaint to the supervisor who will investigate and attempt to resolve the issue, if the supervisor is unable to resolve the issue she will report it to the owner who will attempt to resolve the issue.

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: Contract with a service provider billed separately.

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: We contract with a local pharmacy who bills set-up fees separately

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

☐ Included ☒ Not Included ☐ Extra Fee, From: $ _____ To: $ _____

☒ Comments: We contract with home health agencies who bill separately for services

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: $ 02.00 To: $ 30.00

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

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

☒ Comments: As the event is scheduled

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: Contract with community service providers billed separately. We provide transportation for outings

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: We have smart tvs and antennas

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:

Any required service that can be contracted through community providers may be utilized

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:

Provided through in home care service providers

SECTION 9 - INDIVIDUAL SUBMITTING THE DISCLOSURE / MAILING INSTRUCTIONS

Name of individual completing the form	Title
Shelley Pillado	CEO

Company / Affiliation
HolistiCare Homes

Address (*number and street*)
64180 Brick Church Rd

City, state, ZIP code		
Cassopolis	Michigan	49031

Telephone number	Fax number	E-mail address
(574) 360-8132	( )	shelley@holisticarehomes.com

Verified by (*name*)	Title
Shelley Pillado	CEO

Verified by (*signature*)	Date (*month, day, year*)
Shelley Pillado	8/15/2024 12:07:52 PM

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*)