

Adult Family Home Disclosure of Services Required by RCW 70.128.280

HOME / PROVIDER <i>Bethel Care, LLC</i>	LICENSE NUMBER <i>751594</i>
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NOTE: The term “the home” refers to the adult family home / provider listed above.

The scope of care, services, and activities listed on this form may not reflect all required care and services the home must provide. The home may not be able to provide services beyond those disclosed on this form, unless the needs can be met through “reasonable accommodations.” The home may also need to reduce the level of care they are able to provide based on the needs of the residents already in the home. For more information on reasonable accommodations and the regulations for adult family homes, see [Chapter 388-76](#) of Washington Administrative Code.

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About the Home

1. PROVIDERS STATEMENT (OPTIONAL)

The optional provider’s statement is free text description of the mission, values, and/or other distinct attributes of the home.

2. INITIAL LICENSING DATE

Feb. 23, 2010

3. OTHER ADDRESS OR ADDRESSES WHERE PROVIDER HAS BEEN LICENSED:

none

4. SAME ADDRESS PREVIOUSLY LICENSED AS:

Bethel Care, LLC

5. OWNERSHIP

- Sole proprietor
- Limited Liability Corporation
- Co-owned by:
- Other:

Personal Care

"Personal care services" means both physical assistance and/or prompting and supervising the performance of direct personal care tasks as determined by the resident's needs, and does not include assistance with tasks performed by a licensed health professional. (WAC 388-76-10000)

1. EATING

If needed, the home may provide assistance with eating as follows:

2. TOILETING

If needed, the home may provide assistance with toileting as follows:

The home provides ~~eating~~ ^{toileting} assistance from cuing & monitoring, ^{to total assistance.}

3. WALKING

If needed, the home may provide assistance with walking as follows:

From cuing and monitoring to a one person total assist.

4. TRANSFERRING

If needed, the home may provide assistance with transferring as follows:

From cuing and monitoring to a one person total assist

5. POSITIONING

If needed, the home may provide assistance with positioning as follows:

From cuing and monitoring to a one person total assist

6. PERSONAL HYGIENE

If needed, the home may provide assistance with personal hygiene as follows:

From cuing and set up to total one person assist.

7. DRESSING

If needed, the home may provide assistance with dressing as follows:

From cuing and set up to total assistance.

8. BATHING

If needed, the home may provide assistance with bathing as follows:

From cuing and set up to total assistance.

9. ADDITIONAL COMMENTS REGARDING PERSONAL CARE

roll in shower, Room with private bathroom is also available.

Medication Services

If the home admits residents who need medication assistance or medication administration services by a legally authorized person, the home must have systems in place to ensure the services provided meet the medication needs of each resident and meet all laws and rules relating to medications. (WAC 388-76-10430)

The type and amount of medication assistance provided by the home is:

- self medication to medication administration

ADDITIONAL COMMENTS REGARDING MEDICATION SERVICES

- Provider is an RN and also home has a state nurse delegator. All caregivers have insulin

administration - nurse delegation training.

Skilled Nursing Services and Nurse Delegation

If the home identifies that a resident has a need for nursing care and the home is not able to provide the care per chapter 18.79 RCW, the home must contract with a nurse currently licensed in the state of Washington to provide the nursing care and service, or hire or contract with a nurse to provide nurse delegation. (WAC 388-76-10405)

The home provides the following skilled nursing services:

none

The home has the ability to provide the following skilled nursing services by delegation:

insulin administration, medication administration

ADDITIONAL COMMENTS REGARDING SKILLED NURSING SERVICE AND NURSING DELEGATION

- Provider is an RN, the home works with a state nurse delegator.

Specialty Care Designations

We have completed DSHS approved training for the following specialty care designations:

- Developmental disabilities
- Mental illness
- Dementia

ADDITIONAL COMMENTS REGARDING SPECIALTY CARE DESIGNATIONS

Staffing

The home's provider or entity representative must live in the home, or employ or have a contract with a resident manager who lives in the home and is responsible for the care and services of each resident at all times. The provider, entity representative, or resident manager is exempt from the requirement to live in the home if the home has 24-hour staffing coverage and a staff person who can make needed decisions is always present in the home. (WAC 388-76-10040)

- The provider lives in the home.
- A resident manager lives in the home and is responsible for the care and services of each resident at all times.
- The provider, entity representative, or resident manager does not live in the home but the home has 24-hour staffing coverage, and a staff person who can make needed decisions is always present in the home.

The normal staffing levels for the home are:

- Registered nurse, days and times: twice a week and as needed
- Licensed practical nurse, days and times: _____
- Certified nursing assistant or long term care workers, days and times: Registered nursing assistance 24/7
- Awake staff at night
- Other:

ADDITIONAL COMMENTS REGARDING STAFFING

Cultural or Language Access

The home must serve meals that accommodate cultural and ethnic backgrounds (388-76-10415) and provide informational materials in a language understood by residents and prospective residents (Chapter 388-76 various sections)

The home is particularly focused on residents with the following background and/or languages:

English, tagalog, ilocano

ADDITIONAL COMMENTS REGARDING CULTURAL OR LANGUAGE ACCESS

Medicaid

The home must fully disclose the home's policy on accepting Medicaid payments. The policy must clearly state the circumstances under which the home provides care for Medicaid eligible residents and for residents who become eligible for Medicaid after admission. (WAC 388-76-10522)

- The home is a private pay facility and does not accept Medicaid payments.
- The home will accept Medicaid payments under the following conditions:

ADDITIONAL COMMENTS REGARDING MEDICAID

Activities

The home must provide each resident with a list of activities customarily available in the home or arranged for by the home (WAC 388-76-10530).

The home provides the following:

The home will arrange pastoral / chaplain visits depending on client preference.

ADDITIONAL COMMENTS REGARDING ACTIVITIES



Medicaid Provider Disclosure Statement

Completion and submission of this form is a federal and state requirement and a condition of participation in Medicaid reimbursement (see instructions for specific citations). Full and accurate disclosure of ownership as well as financial, managerial, and controlling interests is required. Submission of this form to DSHS is also required for changes in ownership, managing employees, or controlling interests. Any failure to submit the requested information may cause the Department to refuse to enter into an agreement or contract with the individual or entity, or to terminate existing agreements. See the instructions for definitions of the terms used in this form.

Please answer all questions as of the current date. If additional space is needed use an attached sheet.

Sections:

- I. Identifying Information of Provider Entity
- II. Individuals with Ownership Interest
- III. Managing Employees and other Controlling Interests
- IV. Organizations with Ownership or Management Interest
- V. Subcontractor Information
- VI. Criminal Offenses
- VII. Suspension or Debarment
- VIII. Status Changes
- IX. Signature

I. Enrolling Provider's Information (see instructions)

PROVIDER NAME (LEGAL NAME) Ana Marie G. Idio	FEDERAL TAX ID: SSN / FEIN 26-1094732
DOING BUSINESS AS (DBA) Bethel Care, LLC	NATIONAL PROVIDER IDENTIFIER (NPI) 751594

II. Individuals with Ownership Interest (see instructions)

List each individual who has direct or indirect ownership, separately or in combination, amounting to an ownership interest of 5% or more of the provider listed in Section I. Attach additional pages as necessary.

FIRST NAME Darryl	LAST NAME Idio	DATE OF BIRTH 5/30/65
SOCIAL SECURITY NUMBER 536-37-0693	START DATE	OWNERSHIP PERCENTAGE 50%
STREET NAME AND NUMBER, SUITE, ROOM, ETC. 4002 ELWOOD DR. W. U.P.		CITY STATE ZIP CODE WA 98466

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or individual with controlling interest of the provider listed in Section I, list related individual(s):

FIRST NAME Ana Marie	LAST NAME Idio	RELATIONSHIP spouse
FIRST NAME	LAST NAME	RELATIONSHIP

List each individual who has direct or indirect ownership, separately or in combination, amounting to an ownership interest of 5% or more of the provider listed in Section I. Attach additional pages as necessary.

FIRST NAME Ana Marie	LAST NAME Idio	DATE OF BIRTH 7/26/64
SOCIAL SECURITY NUMBER 539-21-9400	START DATE	OWNERSHIP PERCENTAGE 50%
STREET NAME AND NUMBER, SUITE, ROOM, ETC. 4002 ELWOOD DR. W. U.P.		CITY STATE ZIP CODE WA 98466

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or individual with controlling interest of the provider listed in Section I, list related individual(s):

FIRST NAME Darryl	LAST NAME Idio	RELATIONSHIP spouse
FIRST NAME	LAST NAME	RELATIONSHIP

II. Individuals with Ownership Interest (continued)

List each individual who has direct or indirect ownership, separately or in combination, amounting to an ownership interest of 5% or more of the provider listed in Section I. Attach additional pages as necessary.

FIRST NAME <i>Ø</i>	LAST NAME	DATE OF BIRTH
SOCIAL SECURITY NUMBER	START DATE	OWNERSHIP PERCENTAGE
STREET NAME AND NUMBER, SUITE, ROOM, ETC.		CITY STATE ZIP CODE

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or individual with controlling interest of the provider listed in Section I, list related individual(s):

FIRST NAME	LAST NAME	RELATIONSHIP
FIRST NAME	LAST NAME	RELATIONSHIP

List each individual who has direct or indirect ownership, separately or in combination, amounting to an ownership interest of 5% or more of the provider listed in Section I. Attach additional pages as necessary.

FIRST NAME <i>Ø</i>	LAST NAME	DATE OF BIRTH
SOCIAL SECURITY NUMBER	START DATE	OWNERSHIP PERCENTAGE
STREET NAME AND NUMBER, SUITE, ROOM, ETC.		CITY STATE ZIP CODE

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or individual with controlling interest of the provider listed in Section I, list related individual(s):

FIRST NAME	LAST NAME	RELATIONSHIP
FIRST NAME	LAST NAME	RELATIONSHIP

III. Managing Employees and other Controlling Interests (see instructions)

List each managing employee and other controlling interests (e.g. members of a board of directors or an officer) of the provider listed in Section I. Attach additional pages as necessary.

FIRST NAME <i>Minerva</i>	LAST NAME <i>Encarnacion</i>	
DATE OF BIRTH <i>5-6-1960</i>	SOCIAL SECURITY NUMBER <i>535-67-0317</i>	START DATE <i>7-2-2014</i>
STREET NAME AND NUMBER, SUITE, ROOM, ETC. <i>16901 13th Ave. Ct. E. Spanaway, WA 98387</i>		CITY STATE ZIP CODE

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or controlling interest of the provider listed in Section I, list related individual(s):

FIRST NAME <i>N/A</i>	LAST NAME	RELATIONSHIP
FIRST NAME	LAST NAME	RELATIONSHIP

List each managing employee and other controlling interests (e.g. members of a board of directors or an officer) of the provider listed in Section I. Attach additional pages as necessary.

FIRST NAME	LAST NAME	
SOCIAL SECURITY NUMBER	START DATE	DATE OF BIRTH
STREET NAME AND NUMBER, SUITE, ROOM, ETC.		CITY STATE ZIP CODE

III. Managing Employees and Other Controlling Interests (continued)

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or controlling interest of the provider listed in Section I, list related individual(s):

FIRST NAME	LAST NAME	RELATIONSHIP
FIRST NAME	LAST NAME	RELATIONSHIP

List each managing employee and other controlling interests (e.g. members of a board of directors or officers) of the provider listed in Section I. Attach additional pages as necessary.

FIRST NAME	LAST NAME			
SOCIAL SECURITY NUMBER	START DATE	DATE OF BIRTH		
STREET NAME AND NUMBER, SUITE, ROOM, ETC.		CITY	STATE	ZIP CODE

If the individual being disclosed is related (spouse, parent, child, sibling) to another owner, managing employee, or controlling interest of the provider listed in Section I, list related individual(s):

FIRST NAME	LAST NAME	RELATIONSHIP
FIRST NAME	LAST NAME	RELATIONSHIP

IV. Organizations with Ownership or Management Interest (see instructions)

List each office, organization, corporation or entity that has a management interest or direct/indirect ownership separately or in combination, amounting to an ownership interest of 5% or more in the provider listed in Section I. Attach additional pages as necessary.

ORGANIZATION NAME (LEGAL NAME)	FEDERAL TAX ID - FEIN	CHECK ONE <input type="checkbox"/> Ownership Interest <input type="checkbox"/> Management Interest		
DOING BUSINESS AS (DBA)	START DATE	OWNERSHIP PERCENTAGE		
PRIMARY BUSINESS STREET ADDRESS		CITY	STATE	ZIP CODE

Mailing Address (PO Box) for the disclosed organization, if different from Primary Business Address

MAILING ADDRESS	CITY	STATE	ZIP CODE
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Business Locations for the disclosed organization, if different from the Primary Business Address

STREET NAME AND NUMBER, SUITE, ROOM, ETC.		CITY	STATE	ZIP CODE
STREET NAME AND NUMBER, SUITE, ROOM, ETC.		CITY	STATE	ZIP CODE

List each office, organization, corporation or entity that has a management interest or direct/indirect ownership separately or in combination, amounting to an ownership interest of 5% or more in the provider listed in Section I. Attach additional pages as necessary.

ORGANIZATION NAME (LEGAL NAME)	FEDERAL TAX ID - FEIN	CHECK ONE <input type="checkbox"/> Ownership Interest <input type="checkbox"/> Management Interest		
DOING BUSINESS AS (DBA)	START DATE	OWNERSHIP PERCENTAGE		
PRIMARY BUSINESS STREET ADDRESS		CITY	STATE	ZIP CODE

Mailing Address (PO Box) for the disclosed organization, if different from Primary Business Address

MAILING ADDRESS	CITY	STATE	ZIP CODE
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IV. Organizations with Ownership or Management Interest (continued)

Business Locations for the disclosed organization, if different from the Primary Business Address

STREET NAME AND NUMBER, SUITE, ROOM, ETC.	CITY	STATE	ZIP CODE
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STREET NAME AND NUMBER, SUITE, ROOM, ETC.	CITY	STATE	ZIP CODE
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V. Subcontractor Information (see instructions)

List each person with an ownership or controlling interest in any subcontractor in which the provider listed in Section I has direct or indirect ownership of 5% or more. Attach additional pages as necessary.

NAME AND TITLE	SSN / TIN	PERCENTAGE
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ADDRESS	CITY	STATE	ZIP CODE
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NAME AND TITLE	SSN / TIN	PERCENTAGE
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ADDRESS	CITY	STATE	ZIP CODE
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Does any owner of the provider listed in Section I also have an ownership or controlling interest of 5% or more in any other entity? Attach additional pages as necessary.

NAME AND TITLE	SSN / TIN	PERCENTAGE
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ADDRESS	CITY	STATE	ZIP CODE
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VI. Criminal Offenses (see instructions)

List each individual who has ownership, controlling interest, is an agent, managing employee, officer, or member of the board of directors of the provider listed in Section I and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XVIII, XIX, or XX, since the inception of those programs. Attach additional pages as necessary.

NAME AND TITLE	SSN / TIN	PERCENTAGE
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ADDRESS	CITY	STATE	ZIP CODE
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NAME AND TITLE	SSN / TIN	PERCENTAGE
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ADDRESS	CITY	STATE	ZIP CODE
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VII. Suspension or Debarment (see instructions)

Federal statutes and regulations clearly prohibit states from paying for items or services furnished, ordered or prescribed by excluded parties. States are required to search the exclusions databases by the name of a provider entity seeking to participate in the program and also by the name of any owner, managing employee, or controlling interests including officers and members of a board of directors.

Have you, any of your employees, or any individual who has an ownership or controlling interest of the provider listed in Section I ever been placed on the federal Office of the Inspector General, Health and Human Services (OIG/HHS) exclusions list or on the System for Award Management (SAM), or otherwise been suspended or debarred from participation in Medicare, Medicaid, or Title XVIII, XIX, or XX services programs. If yes, list each person below. Attach additional pages as necessary. The lists of excluded individuals can be found at: <http://exclusions.oig.hhs.gov/search.aspx> and <https://www.sam.gov>.

NAME AND TITLE	SSN / TIN	DATE OF BIRTH
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ADDRESS	CITY	STATE	ZIP CODE
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NAME AND TITLE	SSN / TIN	DATE OF BIRTH
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ADDRESS	CITY	STATE	ZIP CODE
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VIII. Status Changes (see instructions)

Is a change of ownership anticipated within the next year? Yes No

Is this facility operated by a management company or leased in whole or partly by another organization? .. Yes No

If yes, list date of change in operations: _____

Has there been a past bankruptcy or do you anticipate filing for bankruptcy within the next year? Yes No

If yes, when?

IX. Signature (see instructions)

Anyone who knowingly and willfully makes or causes to be made a false statement or representation of this statement may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the appropriate state agency. By signature I certify that the information provided within, is true and correct and I fully understand the consequences as explained above.

NAME OF INDIVIDUAL COMPLETING THIS FORM

Ana Marie Idio

TITLE OF INDIVIDUAL COMPLETING THIS FORM

PROVIDER / owner

SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM

Ana Marie Idio

DATE

1/6/15