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Washington State Department of Social & Health Services
Transforming lives

# Adult Family Home Disclosure of Charges Required by RCW 70.128.280

DATE: 11/29/2016

HOME / PROVIDER'S NAME: GABRIELA'S AFH, INC.

LICENSE NUMBER: 752234

**NOTE:** The term "the home" refers to the adult family home / provider listed above.

The information in this form is meant to help people search for a home that best suits their needs and choices. The lists of services and charges on this form are not necessarily complete or binding. In addition to looking at these forms, potential residents and their family members may wish to contact the home directly by phone or email, interview the providers at the home, and use other available resources to choose a home that most fits their needs.

The care, services, items, and activities listed on this form do not reflect all required and/or available care, services, items, and activities that an adult family home provides for residents. This form may not be used on its own to meet the requirements of section 388-76-10540 WAC. Unless listed individually on this form, charges for care, services, items, and activities are included in the daily and/or monthly rate. For more information on reasonable accommodations and the regulations for adult family homes, see Chapter 388-76 of Washington Administrative Code or call the Long Term Care Ombuds with questions at 1-800-562-6028.

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## Medicaid Information

Medicaid payments made by DSHS are considered payment in full for the services, items, activities, and room and board. Supplementation (Medicaid payments plus additional payment/s) of this rate is only allowed in limited situations. See WAC 388-105-0050 or speak to your case manager for more information on supplementation.

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 may change any policy with a 30 day written notice.

☐ The home is a private pay facility and does not accept Medicaid payments.

☒ The home will accept Medicaid payments under the following conditions:
IF PRIVATE PAY FOR 2-3 YEARS OR OTHERWISE DISCUSSED AT THE TIME OF ADMISSION

ADDITIONAL COMMENTS REGARDING MEDICAID: THE CLIENT OR POA IS RESPONSIBLE WITH THE APPLICATION FOR MEDICAID AND IS RESPONSIBLE W/PRIVATE PAY UNTIL APPROVED FOR MEDICAID.

## Admission Fee * N/A

If the home requires payment of an admission fee, the home must give full disclosure in writing. (WAC 388-76-10540)

* This section does not apply to residents receiving Medicaid, as this is either covered by Medicaid or not applicable to residents paying Medicaid.

The home charges the following admission fee: N/A

ADDITIONAL COMMENTS REGARDING ADMISSION FEE N/A

**Deposits ***

If the home requires payment of a deposit, the home must give full disclosure in writing. (WAC 388-76-10540)

The home requires the following deposit(s): N/A

| DEPOSIT PURPOSE | DEPOSIT AMOUNT |
|---|---|
| | $ |
| | $ |
| | $ |
| | $ |

ADDITIONAL COMMENTS REGARDING DEPOSITS

**Prepaid Charges ***

If the home requires prepaid charges, the home must give full disclosure in writing. (WAC 388-76-10540)

The home requires the following prepayment for charge(s): N/A

| CHARGE PURPOSE | CHARGE AMOUNT |
|---|---|
| | $ |
| | $ |
| | $ |
| | $ |

ADDITIONAL COMMENTS REGARDING PREPAID CHARGES

N/A

**Other Fees / Charges**

If the home requires payment of other fees or charges, the home must give full disclosure in writing. (WAC 388-76-10540)

The home requires the following other fees / charges:

| FEE / CHARGE PURPOSE | FEE / CHARGE AMOUNT |
|---|---|
| | $ |
| | $ |
| | $ |
| | $ |

ADDITIONAL COMMENTS REGARDING OTHER FEES / CHARGES

NO EXTRA CHARGES, ALL CHARGES ARE INCLUDED IT ON MONTHLY CHARGES

The home charges the following minimum stay fees: N/A

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If the resident dies, is hospitalized, or transferred or discharged from the home, the following amount or portion of the deposits and/or prepaid funds not be refunded (in other words, will be retained) by the home [illegible] RCW 70.129.060:

IF RESIDENT WAS PLACED BY ON ANGENCY AND THE RESIDENT DIES ON OR AROUND THE 15th of the month, GABRIELA'SAFH, INC WILL ASK THAT THE REMAINING OF THE MONTHLY CHARGES NOT TO REFUNDED

**Daily and/or Monthly Rates ***

Provider's statement:

GABRIELA'SAFH, INC. HAS MONTHLY CHARGES BASED ON THE LEVEL OR CARE (THE ASSESSMENT) AND WILL ALWAYS GAVE NOTICE IF THE LEVEL OF CARE HAS CHANGED (30 DAYS NOTICE OF ANY INCREASE)

| | Low | High |
|---|---|---|
| ☒ The home charges the following monthly rate: | $ 7000.00 | $ 10.000.00 |
| ☐ The home charges the following daily rate: | Low $ | High $ |

**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)

| | Low | High |
|---|---|---|
| **Eating**<br>The following charge(s) may be added to the daily/monthly rate:<br>• Low (usually independent but needs some assistance)<br>• Medium (needs assistance approximately half the time)<br>• High (needs physical help daily)<br>☒ **Included in monthly rate.** | $_____ | $_____ |
| **Toileting**<br>The following charge(s) may be added to the daily/monthly rate:<br>• Low (usually independent but needs some assistance)<br>• Medium (needs assistance approximately half the time)<br>• High (needs physical help daily)<br>☒ **Included in monthly rate.** | $_____ | $_____ |
| **Transferring**<br>The following charge(s) may be added to the daily/monthly rate:<br>• Low (usually independent but needs some assistance)<br>• Medium (needs assistance approximately half the time)<br>• High (needs physical help daily)<br>☒ **Included in monthly rate** | $_____ | $_____ |
| **Personal hygiene**<br>The following charge(s) may be added to the daily/monthly rate:<br>• Low (usually independent but needs some assistance)<br>• Medium (needs assistance approximately half the time)<br>• High (needs physical help daily) | $_____ | $_____ |

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| | | |
|---|---|---|
| ☒ **Included in monthly rate** | | |
| **Dressing**<br>The following charge(s) may be added to the daily/monthly rate:<br>• Low (usually independent but needs some assistance)<br>• Medium (needs assistance approximately half the time)<br>• High (needs physical help daily)<br>☒ **Included in monthly rate** | Low<br>$_____ | High<br>$_____ |
| **Bathing**<br>The following charge(s) may be added to the daily/monthly rate:<br>• Low (usually independent but needs some assistance)<br>• Medium (needs assistance approximately half the time)<br>• High (needs physical help daily)<br>☒ **Included in monthly rate** | Low<br>$_____ | High<br>$_____ |
| **Behaviors**<br>The following charge(s) may be added to the daily/monthly rate:<br>• Low (usually independent but needs some assistance)<br>• Medium (needs assistance approximately half the time)<br>• High (needs help daily)<br>☐ **Included in monthly rate** | Low<br>$ 500.00 | High<br>$ 1000.00 |

**Medication and Medical 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)

| | | |
|---|---|---|
| **Medication Services**<br>☒ **Included in monthly rate** | Low<br>$ | High<br>$ |
| **Nurse Delegation Services**<br>☐ **Included in monthly rate** | Low<br>$ 350.00 | High<br>$ 1000.00. |
| **Assessments (full, change of condition, use of medical equipment, etc.)**<br>☐ **Included in monthly rate** | Low<br>$ 250.00 | High<br>$ 350.00. |

**Other Services**

The home must provide notice in writing of the services customarily available in the home and the charges for those services. (WAC 388-76-10530) Other services not included in the daily/monthly rate may include cable television, internet access, haircuts, long-distance phone calls, etc.

**Other Services**

The following charge(s) may be added to the daily / monthly rate:

HAIR CUT - $20 - 30
ASSESSMENTS FULL $250.00 - 350.00 (EVERY ~~YEAR~~)
NURSE DELEGATION - 350 - INITIAL & 150 - 200 EVERY 3 month
- 1000 .. INITIAL FOR DIABETES CARE & $150-$200 every 3mm
PROVIDED BY NURSE ~~DELEGATOR~~ BUT PAYED FOR BY CLIENT OR POA

**Items**

The home must provide notice in writing of items customarily available in the home and the charges for those items. (WAC 388-76-10530) Items not included in the daily/monthly rate may include premium brand shampoos and soaps, razors, undergarments, disposables, etc.

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**Items**

The following charge(s) may be added to the daily / monthly rate:

**Activities**

The home must provide notice in writing of activities customarily available in the home and the charges for those items. (WAC 388-76-10530) Activities not included in the daily/monthly rate may include trips to special events, shopping excursions, etc.

**Items**

The following charge(s) may be added to the daily / monthly rate: N/A

**Other Charges (not covered by Medicaid, Medicare, or other programs)**

**Other charges**

THERE WILL BE NO OTHER CHARGES BUT THE FAMILY IS RESPONSIBLE WITH ANY SPECIAL CREAMS, SHOMPOOS

**Resident Acknowledgement of Receipt**

**Resident:** WAC 388-76-10532 requires adult family homes to provide a copy of the Disclosure of Charges form to residents prior to or upon admission. By signing this form, you acknowledge that you have received a copy of this disclosure.

| SIGNATURE | DATE | PRINTED NAME |
|---|---|---|
| | | |

**Provider:**

| SIGNATURE | DATE | PRINTED NAME |
|---|---|---|
| | | |

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