New Client[ ]  Re-enroll[ ]

Annual[ ]  Update[ ]

Name: enter text Medicaid #: enter text DOB: enter text

Type of residence: Assisted Living Facility [x]  Independent Living Facility [ ]

Alzheimer’s/Secure Unit [x]  Own Home/Apartment [ ]

Facility Name: enter text

Facility Address: enter text

Facility Phone Number: enter text

I, resident name agree to pay $rent amount per month for room and board at this facility. I understand that there may be a more detailed contract with the facility / landlord and I will be subject to the terms of that agreement.

The rate is broken down into the following components:

|  |  |  |  |
| --- | --- | --- | --- |
| Room Rate | $ |  Food Costs | $ |
| Electricity | $ |  Gas | $ |
| Water | $ |  Telephone | $ |

DWS allows a deduction for shelter costs (“Room” amount on this agreement) and a utility allowance, if part of the rate is being paid toward heating/cooling costs.

This rate is effective enter date pending my approval for the New Choices Program.

 enter text enter text

|  |  |  |  |
| --- | --- | --- | --- |
| Resident Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Facility Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature of Resident or Responsible Partyenter text |  |  | Facility Signatureenter text |
| Name of Responsible Partyenter text |  |  | Title / Position |

 Relationship to Resident

**Emergency Contact Information:**

Name: enter text Relationship to Resident: enter text

Phone: enter text

**Case Management Agency (CMA) Information:**

CMA Name: enter text CMA Phone: enter text

CMA Address: enter text