New Client Re-enroll

Annual Update

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

Type of residence: Assisted Living Facility  Independent Living Facility

Alzheimer’s/Secure Unit  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 Party  enter text |  |  | Facility Signature  enter text |
| Name of Responsible Party  enter 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