



ILLINOIS DEPARTMENT OF PUBLIC HEALTH
HEALTH SYSTEMS EVALUATION SECTION
LIFE CARE FACILITIES PROGRAM

2018 Edition

Life Care and Alzheimer’s Special Care Disclosure Questionnaire

This questionnaire is applicable to all Life Care Permitted Facilities. The Alzheimer’s Special Care Disclosure Act (210 ILCS 4/) requires a life care facility that offers to provide care for persons with Alzheimer’s disease through an Alzheimer’s special care unit or center to disclose annually to the Department of Public Health certain specific information concerning the treatment of care for persons with Alzheimer’s disease. All permitted facilities need to respond or they risk their permit being revoked in accordance with (210 ILCS 4/6). Please complete this form by supplying the requested information and any additional documentation, if required, and return to: **dph.lifecare@illinois.gov**

Note: **If your facility does not provide Alzheimer’s care, you will check “No” in Part III to indicate that such care is not available at the facility.*

All life care facilities, including those with no Alzheimer’s special care units, must complete the form in its entirety and return a signed copy along with all applicable attachments to the Life Care Program **no later than November 13th, 2018*

Any questions should be directed to the Life Care Program at 217-782-3986 or **dph.lifecare@illinois.gov*

Part I: LIFE CARE FACILITY GENERAL INFORMATION

Name _____
Street Address _____
City _____
Zip _____
County _____
Telephone _____
Fax _____
Website _____

Life Care Permit
Permit Number _____
Permit Units _____
Facility Units _____

(If permit holder operates under multiple permits, attach a listing of all permits and number of units authorized under each separate permit, and number of units in the facility as Attachment A.)

Permit Holder _____
Street Address _____
Zip _____
County _____
Fax _____
City _____
Telephone _____
Website _____

Type of Ownership: _____
1. Sole Proprietorship
2. General Partnership
3. Not-for-Profit
4. For-Profit
5. Limited Partnership
6. Limited Liability
7. Other(specify)

(If site owner is same as permit holder, enter "same as permit holder" as appropriate)

Site Owner _____
Street Address _____
Zip _____
County _____
Fax _____
City _____
Telephone _____
Website _____

(If operator is same as permit holder, enter "same as permit holder" as appropriate)

Site Owner _____
Street Address _____
Zip _____
County _____
Fax _____
City _____
Telephone _____
Website _____

Administrator _____
Title _____
Street Address _____
Zip _____
County _____
Fax _____
City _____
Telephone _____
E-mail _____

1.1. The Life Care Facilities Act requires permit holders to provide maintenance services and at least one of the following services: nursing, medical or personal services under the regular monthly fee set forth in the life care contract or residency agreement. Please indicate below which additional service is available to residents should they require a higher level of care than can be provided in the independent living units.

- a Nursing Service b Medical Service c Personal Care

1.2. A CCRC (Continued Care Retirement Communities) is typically defined as a community that provides individuals with residence homes, support services, assisted living and long term nursing care within the same community. What services are provided? Please check all that apply.

- a Residence Home/Apartments e Licensed Nursing Home
b Licensed Assisted Living Facilities f Nursing Services
c Certified Supportive Living Facilities g Personal Care Service
d Medical Service h Not a CCRC

1.3. If your Life care facility is a part of a CCR, is it accredited through the Continuing Care Accreditation Commission (CCAC)?
(specify here)

1.4. Please state the current Entrance fees that your facility charges a new resident? Please mark all that may apply.
(specify here)

1.5. Please state the amount of Monthly fees that your facility charges per resident? Please mark all that may apply.
Other(specify)

1.6. After the 14 day recession period do you provide the resident a refund if they move, pass away, etc.?
(If Yes, what percentage of the total amount is returned. Please attach a document with details. Label attachment as Attachment A part 1)

Part II: LIFE CARE CONTRACTS AND REQUIRED DISCLOSURE

2.1. A “life care contract” is defined as a contract to provide to a person for the duration of such person’s life or for a term in excess of one year, nursing services, medical services or personal care services, in addition to maintenance services for such person in a facility, conditioned upon the transfer of an entrance fee to the provider of such services in addition to or in lieu of the payment of regular periodic charges for the care and services involved. Please enclose a copy of all life care contract form(s) currently utilized by the facility. (Label the first page of each life care contract form Attachment B.)

2.2. At the time of or prior to the execution of a life care contract and the transfer of any money or other property to a provider or escrow agent, the provider shall deliver to the resident a copy of a financial disclosure statement reflecting the provider’s financial condition. The statement shall include, but is not limited to, the disclosure of short term assets and liabilities. Please provide a copy of your most current “financial disclosure statement” that is provided to potential life care residents. (Label the “financial disclosure statement” Attachment C.)

Part III: AVAILABILITY OF ALZHEIMER’S CARE

3.1. Does the facility currently offer to provide care for persons with Alzheimer’s disease through an Alzheimer’s Special Care Unit or Center?

(If Yes, please provide a copy of the latest disclosure document that has been provided to the Department of Public Health’s licensing program pursuant to the requirements of Section 15 of The Alzheimer’s Special Care Disclosure Act as Attachment D.)

Part IV: VACCINATIONS

4.1. Does the facility currently have policies and procedures in place that meet the requirements stipulated in the Life Care Facilities Act, Sec. 10.1 regarding the provision of vaccinations to residents?

(If No, please provide a detailed explanation as to how resident vaccinations are handled at your particular facility as Attachment E.)

Part V: AVAILABILITY FOR FOODS

5.1. How many meals the facility provides for a day?

5.2. Average cost for a meal: \$

5.3. Are snacks available for 24 hours?

(If No, please provide how long the snacks available for a day: _____ hours)

5.4. What kinds of snacks are provided mainly? Write down the answer in the cell

Part VI: ESCROW REQUIREMENTS

6.1. When required by subsections (e) and (f) of Section 396.50 of the Life Care Facilities Contract Code, the provider must establish and maintain on a current basis, an escrow account and/or letter of credit with a bank, trust company, or other financial institution located in Illinois. To allow the Department to determine the provider’s compliance with this requirement, please provide a complete, detailed written description of any long-term financing of the facility, amortization schedules, and the calculations used to determine the appropriate escrow or letter of credit amount required by the act and code. Also, provide a current copy of the escrow agreement or letter of credit. (Label this information Attachment F.)

Part VII: CERTIFICATION

7.1. The information provided herein, and appended thereto, is complete and accurate to the best of my knowledge and belief. The Life Care program may follow-up to substantiate any information reported herein.

Signature _____
Printed Name _____
Title _____
Date _____