

**STATE OF KANSAS
INSURANCE DEPARTMENT**

**CONTINUING CARE PROVIDER
ANNUAL DISCLOSURE STATEMENT**

This Disclosure Statement must be delivered to all prospective residents. This Disclosure Statement must be made available to current residents upon request.

PART I – GENERAL DISCLOSURES

A. Provider: _____

B. Administrative
Office:

_____ (Street Address)

_____ (City) (State) (Zip)

_____ (Phone)

C. Continuing Care
Facility:

_____ (Street Address)

_____ (City) (State) (Zip)

_____ (Phone)

D. Chief Executive Officer
Executive Director:

_____ (Name)

_____ (Title)

_____ (Phone)

E. Type of Provider:

1. Defined Voluntary
2. For Profit Not-for-Profit
3. Corporation Partnership Individual
 Other: _____
4. Entrance fee: \$ _____
5. Periodic fee: \$ _____ per _____

PART II – ITEMIZED DISCLOSURES

Please read each item below, check the appropriate answer and provide the necessary documentation as requested. Incomplete applications cannot be processed and will be returned.

- A. Provider is individually owned. Please attach as “Exhibit A” the name(s) of any individual(s) who constitute the provider.
 Provider is not individually owned.
- B. Provider is a corporation, partnership or other legal entity. Please attach as “Exhibit B” the names of the officers, directors, trustees, managing or general partners of the provider.
 Provider is not a corporation, partnership or other legal entity.
- C. Provider is a corporation. Please attach as “Exhibit C” the name(s) of any individual(s) who own(s) 10% or more of the stock of such corporation.
 Provider is not a corporation or, if a corporation, no individual owns 10% or more of such corporation.
- D. Check here if any officer, director or owner of provider has been convicted of any crime or been a party to any civil action claiming fraud, embezzlement, fraudulent conversion or misappropriation of property, which resulted in a judgment against such person(s). Please attach as “Exhibit D” the name(s) of such person(s).
 There are no convictions or judgments against officials, directors or owners.
- E. Check here if any person(s) has/have had any state or federal license or permit related to care and housing suspended or revoked. Please attach as “Exhibit E” the name(s) of any person(s) who has/have had any state or federal license or permit related to care and housing suspended or revoked.
 No suspensions or revocations.

F. _____ Provider/Manager has experience in the operation of homes providing continuing care. Please attach as “Exhibit F” a statement of the years of experience of the provider and/or manager in the operation of homes providing continuing care.

_____ Provider/Manager has no experience.

G. _____ Provider is operated on a for-profit basis. Please attach as “Exhibit G” the name(s) and business address(es) of any individual(s) having any ownership or beneficial interest in the provider and a description of such interest in or occupation with the provider.

_____ Provider is not for profit.

H. _____ Provider is affiliated with a religious, charitable or non-profit organization. Please attach as “Exhibit H” a statement identifying any religious, charitable or non-profit organization with which the provider is affiliated and the extent of that affiliation. Include in the exhibit any information regarding the extent to which an affiliated organization will be responsible for the financial and contractual obligations of the provider.

_____ Provider is unaffiliated.

I. _____ Provider (or its affiliates, if any) is/are exempt from the payment of Federal income tax under Section _____ of the Internal Revenue Code.

_____ Provider is not exempt from Federal income tax.

J. _____ Provider is exempt from local property tax.

_____ Provider is not exempt from local property tax.

PART III – ANNUAL AUDIT

Important information PLEASE READ:

- The continuing care provider is required to have an annual certified audit prepared by a Certified Public Accountant and to provide a copy of the audit to the Kansas Insurance Department.
- A copy of this audit must be made available to any resident or perspective resident upon request.
- This disclosure statement, and the information contained herein and attached hereto, is true and correct to the best of my knowledge.

Signature of CEO or Executive Director