St. Francis
HEALTHCARE SYSTEM OF HAWAII
A Legacy of Caring for Hawaii's People

St. Francis Adult Day Center

Participant Admission Agreement and Application

St. Francis Adult Day Center (SFADC) provides a therapeutic, social, educational, and recreational adult day care program certified by the Department of Human Services, State of Hawaii. The program operates Monday through Friday from 6:30 a.m. to 5:30 p.m. and is located in the St. Francis Intergenerational Center at 91-1758 Oohao Street, Ewa Beach, HI 96706. St. Francis Adult Day Center is a program of St. Francis Healthcare System of Hawaii.

Services and Goals
A special plan of care will be developed for participants to ensure their comfort, safety and enjoyment. The plan will focus on maximizing the abilities and skills of each individual and will be designed to encourage participation and to develop self-help skills where appropriate. A special emphasis of this program will be intergenerational activities providing mutual opportunities for growth and stimulation for both the adults and the children.

Fees and Payment Policy
A non-refundable $30.00 registration fee is required at the time of enrollment. For those participants on Medicaid, the application fee will not be covered by insurance; therefore, it is the responsibility of the families to pay for the application fee. The daily program fee is $68.00, which includes continental breakfast, lunch, beverages and snacks. A minimum of two days weekly attendance is required. The initial tuition is due and payable before the participant's entry date. Fees are due and payable on the first of each month. If payment is not received by the fifth day of the month, a participant will not be accepted at St. Francis Adult Day Center the next business day. Payment may be made by check or in cash. Checks shall be payable to St. Francis Adult Day Center.

In the event of illness, please notify St. Francis Adult Day Center at (808) 681-0100 the day before or the morning of the first absence. Participants planning vacations or other extended absences are asked to notify St. Francis Adult Day Center two (2) weeks prior to the absence, in writing.

Transportation Agreement
Participants shall arrive at SFADC no earlier than 6:30 a.m. Pick-up must occur no later than 5:30 p.m. or late pick-up charge will apply.

Participant will be picked up by: (Check one)

_____ Family Member

_____ Handi-Van (Handi-Van transportation is to be arranged by family/caregiver)

_____ Taxi

_____ Other, please specify: _____

St. Francis Intergenerational Center, St. Francis Adult Day Center, 91-1758 Oohao Street, Ewa Beach, Hawaii 96706, P: 681-0100; F: 380-4244

Medications Policy
As prescribed by Hawaii Administrative Rules §17-1424-16(a) (6),

- Staff may supervise or remind a participant about the need to take a prescribed medication that is provided to the Center by the family on a daily basis;

- Medications **MUST** "be kept in their original container bearing the prescription label which shows the date filled, the physician's directions for use and the adult participant's name"; and

- "Shall be stored out of reach of participants and returned to the participant or responsible family member at the end of each day."

Medication shall only be supervised. Participant will be reminded to take the medication and staff will ensure that it is taken correctly. State law prohibits staff from directly administering the medication.

Conditions for Termination of Services

1. If a participant's level of care exceeds the level of care that this program is authorized to provide, a referral will be made to a more appropriate facility, such as an adult day health program. Staff will cooperate with families in every way possible to ensure a smooth transition.

2. Each participant and family member/caregiver shall receive a two weeks' notice if the participant is to be discharged from the program. An exception to this policy will be made in the case of wandering, chronic exit-seeking, highly agitated or combative behavior or a sudden change in condition that makes the participant a danger to him/herself or others, where immediate discharge will be imposed.

3. Upon discharge, a discharge summary, including recommendations for continuing care and referral to appropriate agencies for follow-up, shall be documented in the participant's record.

4. Should a participant withdraw, a two-week notice is required. Full payment is required through the participant's last day of attendance.

Date of Application: _____

Referral Source: _____
(e.g. Case/Care Manager, Physical Therapist, Hospital or other)

1. Name of participant:_____
Last *First* *Middle*

2. Address:_____
Street *City* *State* *Zip*

Bill to address (if different from above address):

Name: _____

Address: _____
Street *City* *State* *Zip*

3. Birth Date: _____ Home phone: _____

4. Gender: _____ Birthplace: _____

5. Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

6. Ethnicity: _____

7. Language spoken: _____

8. Education: _____ Former Occupation: _____

   Religion: _____

9. Lives with: _____

10. Diet Restrictions: _____

11. Special Needs

____ None	____ Assist with walking	____ Cane
____ Hearing Aid	____ High Rise Seat	____ Walker
____ Toileting Assist	____ Glasses	____ Wheelchair
____ Other: specify		

Other: (*continued)*

_____

_____

_____

12. In-home services:

____ Companion Aide	____ None	____ Visiting Nurse
____ Meals on Wheels	____ Homemaker Services	____ Bathing Service
____ Other	____ Hospice	____ Home Health

13. Transportation: ____ Handi-Van ____ Family ____ Other

14. Physician - Primary:

_____

Name *Address* *Phone*

Physician - Secondary:

_____

Name *Address* *Phone*

Preferred Hospital: _____

15. Most recent hospitalization: _____ Reason: _____

_____

16. Next of Kin: _____

Name

17. Emergency Contacts: *(#1 should be the preferred, usual, first contact person)*

#1 _____

Name/relationship *Address* *Phone*

#2 _____

Name/relationship *Address* *Phone*

#3 _____

Name/relationship *Address* *Phone*

18. Primary physical and mental health problems:

_____

_____

_____

_____

_____

_____

19. Medications: Please fill out the following section with the medication dosage information found on the prescription bottles:

Medication Name	Dosage	Times per day and hours	Purpose

20. Allergies: _____

21. Skills, interests: _____

_____

22. What would happen if the participant were not in this center? _____

_____

23. Participant will attend St. Francis Adult Day Center on the following days:
(NOTE: A minimum of two days weekly will be billed.)

____ Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday

24. Planned arrival time: _____ Planned pick-up time: _____

25. Please share any additional information that you feel may be valuable to our staff in caring for the needs of your family member:

_____

_____

_____

_____

ACKNOWLEDGEMENT

I have read and understand all of the provisions, and agree to enroll _____
NAME OF PARTICIPANT
in the St. Francis Adult Day Center. Additionally, authorization is hereby given to St. Francis Adult Day Center to contact the Secondary Physician in the event that the Primary Physician, as provided, cannot be reached:

_____
PRINT NAME OF PARTICIPANT or CAREGIVER/GUARDIAN

_____
SIGNATURE

_____
DATE

Agreement reviewed with participant or caregiver/guardian:

_____
ST. FRANCIS ADULT DAY CENTER
PROGRAM DIRECTOR

For Office use only:

Date of Interview:_____

Attendance start date: _____

Date of last physical: _____ Date of TB test: _____
(NOTE: Must be within 90 days of start date)

Staff signature: _____ Date: _____

Attendance end date: _____

Staff signature: _____ Date: _____