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

St. Francis Adult Day Center

Participant Classification Form

Thank you very much for entrusting St. Francis Adult Day Center at the St. Francis Intergenerational Center. Listed below you will need to check which category your loved one falls in. If your loved one falls under Part "A", please sign and return; if your loved one falls under Part "B", please initial each item listed in that category, sign and return.

Participant Name: _____ DOB: _____

Part A

_____ I/We pay out of pocket.

Part B

_____ I/We are Medicaid members.

____ United Healthcare ____AlohaCare ____Ohana _____HMSA ____ Kaiser

_____ Registration fee is not covered by Medicaid. It is the participant/family sole responsibility for any charges that are incurred.

_____ Late pick up fees are not covered by Medicaid. It is the participant/family sole responsibility for any charges that are incurred.

_____ All expenses for field trips are not covered by Medicaid. It is the participant/family sole responsibility for any charges that are incurred.

_____ Extra days that are requested must be authorized ahead of time from participants Field Service Coordinator. If authorization is not given to Program Manager, families will be responsible for Extra Day costs.

_____ Extra showers that are requested must be authorized ahead of time from participants Field Service Coordinator. If authorization is not given to Program Manager, families will be responsible for Extra Shower costs.

_____
Print Caregiver's Name

_____ _____
Caregiver's Signature Date