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

PARTICIPANT ADMISSION AGREEMENT AND APPLICATION

The Franciscan Adult Day Center (FADC) 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 7:00 a.m. to 5:00 p.m. and is located at 2715 Pamoa Road, Honolulu, Hawaii 96822 within the Sisters of St. Francis Convent complex. The program is part of the 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. The daily program fee is $68.00, which includes continental breakfast, lunch, beverages and snacks. A minimum of two days weekly attendance is required. Daily fees are payable in advance of the month, starting on the first day of attendance unless otherwise arranged by the Program Director. **CHECKS SHOULD BE MADE OUT TO: FRANCISCAN CARE SERVICES**

Payment may be made by check or cash. We also accept credit card payment, please request an authorization form.

The FADC cannot provide refunds for days missed due to illness as food; staffing and space have been reserved in advance. However please do notify the FADC at 988-5678 if the participant will not be attending the center as scheduled. Participants planning vacations or other extended absences are asked to notify the FADC by the 26th day of the month prior, to facilitate adjustments to lunch counts and staffing requirements, as well as to avoid any unwanted charges.

A late fee will be charged if a participant is picked up after 5:00 p.m. , this includes Handi-Van pick-ups. Late fees are charged as follows:

5:01 p.m. - 5:05 p.m. = $10
5:06 p.m. - 5:10 p.m. = $10
$10 for each additional 5-minute interval

Participants are to arrive on the designated days that were chosen on the application form. Switching of days and/or making up missed days will not be permitted without prior approval from the Program Director.

Transportation Agreement
Participants shall arrive at FADC no earlier than 7:00 a.m. Pick-up must occur no later than 5:00 p.m. There is no provision for late pick-up after 5:00 p.m. The FADC activity room may be used for other evening activities; therefore, your cooperation in meeting the closing deadline is appreciated.

Participant will be picked up by: (Check one)

_____ Family Member

_____ Handi Van: 8:00 a.m. drop off and 3:00 p.m. pick up reservation is available

_____ Taxi

_____ Other, please specify: _____

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 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 from the program voluntarily, 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):

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 Aide	____ 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 Franciscan Adult Day Center the following days:
(NOTE: A minimum of two days weekly will be billed.)

____ Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday

24. Planned time of arrival: _____ 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 set forth in this agreement and the Franciscan Adult Day Center Handbook, and agree to enroll _____
NAME OF PARTICIPANT
in the Franciscan Adult Day Center. Additionally, authorization is hereby given to Franciscan Adult Day Center to contact the Secondary Physician in the event that the Primary Physician, as provided, can not be reached:

_____
PRINT NAME OF PARTICIPANT or CAREGIVER/GUARDIAN

_____
SIGNATURE

_____
DATE

Agreement reviewed with participant or caregiver/guardian:

_____
FRANCISCAN ADULT DAY CENTER
PROGRAM DIRECTOR

For Office use only:

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: _____