

### APPLICATION FOR ADMISSION

**I wish to apply for admission to the Adult Day Health Program and give permission to the center to make the necessary investigations to determine my eligibility for this program.**

Today's Date: \_\_\_\_\_ Admission Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Gender: M or F                      DOB: \_\_\_\_\_                      Age: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Billing Address (If different than above):

Name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Living Arrangement: (Please circle one or specify)

Live alone      Live with son      Live with daughter      Live with spouse      Live with relative: \_\_\_\_\_

Live with friend      Other: \_\_\_\_\_

Person responsible for care: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different than applicant): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email address: \_\_\_\_\_

Person(s) to notify in case of emergency:

Name	Relationship	Address	Phone Numbers
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Primary Care Physician      Name: \_\_\_\_\_      Address: \_\_\_\_\_      Phone: \_\_\_\_\_

Secondary Care Physician in the event that my Primary Care Physician is not able to be reached:

Name: \_\_\_\_\_      Address: \_\_\_\_\_      Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Medicare #: \_\_\_\_\_      Medicaid #: \_\_\_\_\_

VA #: \_\_\_\_\_



## Admission Packet Contents

- Application for Admission
- List of Required Admission Documents
- Admission Agreement
- Letter to Physician
- Medical History Form (to be completed by physician)
- Hawaii Advance Health Care Directive  
(to be completed with physician and signed by 2 witnesses OR notary public)
- Hawaii POLST Form (to be completed with physician)
- Respiratory Infection Policy
- Client Rights
- Notice of Privacy Practices
- Notice of Nondiscrimination
- Caregiver Pledge
- Admission Checklist
- CACFP Meal Benefit Form
- CACFP Enrollment Statement
- Transportation Waiver
- Consent & Authorization for Photos, Videos, & Transcribed Statements
- Fee Schedule
- Holiday Schedule
- Program Brochure



## Documentation Required Prior to Admission

- Application for Admission
- Admission Agreement
- Medical History Form
- 2 Step TB Clearance
- Hawaii Advance Health Care Directive
- Hawaii POLST Form
- Respiratory Infection Policy
- Admission Checklist
- CACFP Meal Benefit Form
- CACFP Enrollment Statement
- Transportation Waiver
- Consent & Authorization for Photos, Videos, & Transcribed Statements



## Admission Agreement

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### Program Description

The Kauai Adult Day Health Center (KADH) program exists to help disabled adults and kupuna continue to reside in the community by attending to participants health and psychosocial needs and providing caregivers needed day-time relief.

### Eligibility

Individuals enrolled to KADH must meet the following criteria:

1. At least 18 years old
2. Ambulatory, semi-ambulatory, or self-propelled in a wheelchair
3. Possess the strength and endurance to participate in a day long activity program.
4. Inappropriate to remain at home unattended due to frailty, physical or intellectual disability.
5. Has a caregiver committed to caring for the individual living in the community and working with our interdisciplinary team in developing and supporting the plan of care.
6. Documentation of physical examination, MD orders and tuberculosis clearance prior to admission and annually thereafter.
7. During the first 30 days of enrollment, the staff will conduct an “initial assessment”, observing the client daily, to insure against inappropriate placement. At the end of this time, staff will inform the family if the client is/is not appropriate for services.

### Hours of Operation

Regular hours of operation are Mondays through Fridays 7:30 am through 5:30 pm. The program is closed on weekends and the following observed holidays:

- |                        |                     |
|------------------------|---------------------|
| 1. New Year’s Day      | 6. Independence Day |
| 2. President’s Day     | 7. Admission Day    |
| 3. Good Friday         | 8. Labor Day        |
| 4. Memorial Day        | 9. Thanksgiving Day |
| 5. King Kamehameha Day | 10. Christmas Day   |

### Attendance / Absences

Upon admission to the program, participants enroll for specific days of attendance. These assigned days become the participant’s regular schedule. “Switching” days is allowed only with prior authorization as based upon space availability.

### Fees and Billing Policy

1. The monthly rate (see attached) includes lunch, two snacks, and general excise tax. Fees are assessed monthly based upon the participant’s scheduled attendance for the month.

- a. Fees are billed in advance to the financially responsible party in the first business day of the month. **No credit will be provided for absences.**
  - b. Payment is due by the 20<sup>th</sup> of the month, payable to “Ohana Pacific Foundation”.
  - c. Nonpayment will result in suspension in services until payment is made.
  - d. Questions regarding your bill should be directed to our Business Office. They may be contacted at (808) 236-8000, Monday – Friday 8:00 am – 3:30 pm.
2. Daily Drop-in Fees
- Participants may enroll on a drop-in basis with the following stipulations:
- a. Drop-ins will be based on availability.
  - b. Family/caregivers may call 24 hours in advance for availability.
  - c. Payment is due each day by check only, payable to Ohana Pacific Foundation.
3. Early Drop-Offs
- Any arrival that occurs prior to 7:30 am is considered an early drop-off and is subject to the following:
- a. Participants, regardless of their mode of transportation, must not be dropped off at the facility prior to 7:30 am. The facility cannot be held responsible for participants who are left in front of the facility prior to our official hours of operation.
  - b. Early drop offs will not be accepted.
  - c. Continued early drop offs can result in discharge from the program.
4. Late Pick-Ups
- Any pick-up that occurs after 5:30 pm is considered a late pick-up and is subject to the following:
- a. Participants will be asked to sign an acknowledgement that they agree to pay for late pick-up.
  - b. Late pick-up fee is as follows:
    - i. 5:30-5:45      \$25
    - ii. 5:45-6:00     \$50
    - iii. 6:00-6:15    \$75
    - iv. 6:15-6:30     \$100
    - v. \$25 is added for each incremental 15 minutes past 6:30
  - c. Continued late pick-ups can result in discharge from the program.
5. Hospitalization/Illness
- If it is expected that the participant will be absent for an extended period of time due to illness, arrangements may be made to “hold” his/her space for a period up to one month and will continue at previous rate which is non-refundable.
6. Financial Agreement
- The financially responsible party agrees that in consideration of the services to be rendered to the participant, he/she hereby individually obligates himself to pay the account of the Kauai Adult Day Health program in accordance with the regular rates and terms of the facility. Should the account be referred to an attorney for collection, the

financially responsible party shall pay reasonable attorney's fees, collection expenses, and interest rate of 1.5% per month (18% per year).

Should the participant need financial assistance, it may be brought to the attention of the Program Director. Information regarding available community resources can then be provided.

### **Transportation / Drop-Offs and Pick-Ups**

1. Transportation services to and from the facility are not provided. The family is responsible for arranging all transportation and informing staff of arrival and departure times and the name(s) of the person(s) or agency responsible for drop-offs and pick-ups. This includes arrangements made with publicly available transportation.
2. A specific time should be designated for dropping off and picking up your family member. If you plan on changing this scheduled time, you must notify the KADH program staff of this change.
3. When dropping-off or picking-up your family member, notify the KADH staff prior to leaving.
4. Use of transportation other than personal vehicle.
  - a. Use of other transportation services such as public transportation does not relieve the family member from the responsibility of dropping off or picking up the participant between the designated facility hours.
  - b. When it is noted that the participant is being dropped off too early or being picked up too late, the facility will notify the family, and the family is responsible for contacting the carrier to correct the situation.
  - c. If other transportation services will be used for a temporary period, the family will be responsible for notifying the facility staff.
  - d. Continued early drop offs and late pick-ups can result in discharge from the program.

### **Meals**

1. Lunch will be provided for the participant daily. Family is responsible for notifying the Day Health Specialist of any special diet restrictions and/or special textures (e.g., minced, pureed, thickened liquids, etc.) in accordance with Dietitian/Physician recommendation.
2. Daily snacks are also provided.

### **Conditions for Discharge / Termination**

1. A participant may be discharged from the program for any of the following reasons:
  - a. Participant and/or responsible family member requests for voluntary discharge.
  - b. Participant no longer meets the facility's eligibility requirements and/or services are no longer appropriate. All efforts will be made to maintain the participant in the facility's program.
  - c. Participant and/or responsible family member does not adhere to the facility's policies and procedures.
  - d. Failure to pay by end of month.
  - e. Loss of government or private foundation funding.
2. If the participant or responsible family member requests for voluntary discharge from the program, a one-month notification period is required. This may be waived in case of emergency, hospitalization or death.
3. If the facility determines that a participant is no longer appropriate for services and must consequently be discharged from the program, whenever possible, the facility will give the family a one month notice so that an alternative service may be found. However, in situations where a participant's safety or the safety of other participants is of concern, this one-month notice may not be possible.

### **Participant's Health**

1. A physical examination and tuberculin (TB) test are required annually for all participants. If they are not completed prior to the annual date, the participant may be restricted from the facility.
2. Participants who are exhibiting signs and symptoms of an illness may be asked to seek physician's care. The facility nurse will contact the responsible family member to pick up the participant and may not be allowed to attend KADH until cleared by their physician.
3. Participants who attend the program must be free of any communicable disease. If the presence of a communicable disease is suspected, the facility nurse will contact the responsible family to have the participant picked up as soon as possible. The participant will not be allowed to return to the program until his/her physician has cleared the participant of carrying any communicable disease.
4. Family members are responsible for notifying KADH of any hospitalization. Hospitalization / illness may necessitate reassessment for program appropriateness.
5. The facility nurse may administer, supervise, or remind participants about the need to take any prescribed medication.
  - a. Medication must be ordered by the participant's primary care physician and provided by the participant and/or responsible party.
  - b. Medications must be stored in their original container bearing the prescription label which shows the participant's name, date filled, name of medication, dose, frequency, and expiration date.

- c. Medication will be stored out of reach of participants in a locked cabinet and returned to the participant or responsible family member at the end of each day.
6. In case of accidents, the facility staff will administer first aid, and/or transport for medical care as deemed necessary. Responsible party will be notified as soon as practicable.

**In consideration of Adult Day Care and Health services to be rendered by Kauai Adult Day Health Center to \_\_\_\_\_, I, The undersigned, agree to be bound by its terms and conditions.**

\_\_\_\_\_  
**Name/Relationship of Responsible Party**

\_\_\_\_\_  
**Signature of Responsible Party**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name/Title of Witness**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**

**KAUAI ADULT DAY HEALTH CENTER**  
**2943 Kress Street Lihue, HI 96766**  
 Phone: 246-6919  
**MEDICAL HISTORY FORM**

<b>PERSONAL INFORMATION:</b>			
Name:	Address:		
Marital Status:	Birthdate:	Age:	Sex:
Physician:	Telephone:		
Medical Diagnosis:			

<b>RN may administer medications at the Day Health Center</b>	
<b>Present Medications: (Name of Drug, Dosage, Time)</b>	
1	5
2	6
3	7
4	8
(*Clients are at the Center from 7:30a.m. to 5:30p.m. weekdays)	

<b>PERTINENT MEDICAL HISTORY:</b>			
Major Medical Problems:	Yes	No	Specify
Allergies:	Yes	No	Specify
Psychiatric History:	Yes	No	Specify
Surgeries:	Yes	No	Specify
Code Status:	Full Code	Other	Specify <span style="float: right;">(Attach copy of Adv. Directive/ POLST)</span>
Rehab Potential:	Good	Fair	Poor

<b>PHYSICAL EXAMINATION:</b>							
<b>General:</b>	Height	Weight	BP	HR	RR	Vision	Hearing
Date of last TB Skin Test:	Results:			(Please attach)			
Date of last TB Chest Xray:	Results:			(Please attach)			
Date of last Physical Examination:							
<b>Date of last Influenza Vaccination Received:</b>							
<b>Diet:</b> regular (Other dietary recommendations):							
Milk consumption not recommended:					Reason:		
Physician's Comments / Special Precautions:							

May self administer medication while at Day Care.	Yes	No	
Any specific therapeutic procedures or programs?	Yes	No	If yes, Specify:

Physician Certification: I recommend that the patient attends Kauai Adult Day Health Center and certify that the patient's medical condition and related needs are essentially as indicated.

Date	MD
Physician's Signature	

I hereby authorize my physician to release any requested medical information to Kauai Adult Day Health Center, the Department of Human Services and the Agency on Elderly Affairs.

Date	Patient's/ POA Signature
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2943 Kress Street  
Lihue, Kauai, Hawaii 96766  
Ph: (808) 246-6919 or (808) 246-6491 / Fax: (808) 246-6911

Date: \_\_\_\_\_

Attn Dr. \_\_\_\_\_

Mr./Mrs. \_\_\_\_\_ is applying for admission to Kauai Adult Day Health Center. In accordance with State of Hawaii licensing standards, we request that you complete the following:

- Complete and sign the attached medical history form.
- Two (2) step TB clearance is required within the last 12 months. If the client has a history of a positive (+) PPD, a chest x-ray result may be used to meet the requirements for admission.
- POLST
- Advanced Health Directive

Please fax or mail the completed medical history form to the Kauai Adult Day Center at the above address.

Sincerely,

**Theo Papa, RN**

# HAWAI‘I ADVANCE HEALTH CARE DIRECTIVE

My name is:

\_\_\_\_\_  
Last

\_\_\_\_\_  
First

\_\_\_\_\_  
Middle initial

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

## PART 1: HEALTH CARE POWER OF ATTORNEY – DESIGNATION OF AGENT:

I designate the following individual as my agent to make health care decisions for me:

\_\_\_\_\_  
Name and relationship of individual designated as health care agent

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Home Phone Cell Phone E-mail

If I revoke my agent’s authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

\_\_\_\_\_  
Name and relationship of individual designated as health care agent

\_\_\_\_\_  
Street Address City State Zip

\_\_\_\_\_  
Home Phone Cell Phone E-mail

### AGENT’S AUTHORITY AND OBLIGATION:

My healthcare agent should make decisions as I have instructed in Part 2 of this form or as I may otherwise provide orally or in writing. If there are decisions for which I have not provided instructions, I want my agent to make such decisions as I would have chosen to do, basing them on my values, goals, and preferences rather than those of my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

### WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE:

My agent’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

- If I mark this box, my agent’s authority to make health care decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care. I can revoke this authority at any time as long as I have mental capacity.

## PART 2: INDIVIDUAL INSTRUCTIONS (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

### A. END OF LIFE DECISIONS

- If I have an incurable and irreversible condition that will result in my death within a relatively short time, OR
- If I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability, OR
- If the likely risks and burdens of treatment would outweigh the expected benefits.

**THEN** I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: Check only one of the following boxes. You may also initial your selection.

I want to stop or withhold medical treatment that would prolong my life.

**OR**  
 I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

**YOUR NAME:**

\_\_\_\_\_  
Print Your Full Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

**PART 2: INDIVIDUAL INSTRUCTIONS (CONTINUED)** (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

**B. ARTIFICIAL NUTRITION AND HYDRATION - FOOD AND FLUIDS:**

Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in the preceding paragraph A unless I mark the following box.

If I mark this box, artificial nutrition and hydration must be provided under all circumstances as long as it is within the limits of generally accepted healthcare standards.

**C. RELIEF FROM PAIN:**

If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

**D. OTHER**

If I mark this box, the additional instructions or information I have attached are to be incorporated into my care. (Sign and date each added page and attach to this form.)

**E. WHAT IS IMPORTANT TO ME:** (Optional. Add additional sheets if needed.) The things that I value and that make life worth living to me are: (examples: gardening, walking my pet, shopping, participating in family gatherings, attending church or temple):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have attached \_\_\_\_\_ additional sheet/s

My thoughts about when I would not want my life prolonged by medical treatment (Examples include: If I no longer have the mental capacity to make my own decisions, if I have lost all ability to communicate, if I can no longer safely swallow, etc):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have attached \_\_\_\_\_ additional sheet/s



# PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAII

**FIRST follow these orders. THEN contact the patient's provider.** This Provider Order form is based on the person's **current medical condition and wishes**. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

**POLST** is a medical order. It is not an **Advance Directive** and is not intended to replace that document.

Patient's Last Name	
First/Middle Name	
Date of Birth	Date Form Prepared

**A** Choose One

**CARDIOPULMONARY RESUSCITATION (CPR): *\*\* Person has no pulse and is not breathing \*\****

**Yes CPR - Attempt resuscitation** (Section B: Full Treatment required)

**No CPR. Do Not Attempt Resuscitation (Allow Natural Death)**

If patient has a pulse, follow orders in Sections B and C

**B** Choose One

**MEDICAL INTERVENTIONS: *\*\* Person has pulse and/or is breathing \*\****

**Full Treatment – primary goal of prolonging life by all medically effective means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes intensive care as needed.

**Selective Treatment – goal of treating medical conditions and restoring function while avoiding intensive care and resuscitation.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive respiratory support.

**Comfort-Focused Treatment – primary goal of maximizing comfort.** Relieve pain and suffering with medication by any route as needed, use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location.

Additional Orders: \_\_\_\_\_

**C** Choose One

**ARTIFICIALLY ADMINISTERED NUTRITION: *Always offer food and liquid by mouth if feasible and desired.***

(See Directions on next page for information on nutrition & hydration)

No artificial nutrition by tube       Defined trial period of artificial nutrition by tube

Long-term artificial nutrition by tube      Goal: \_\_\_\_\_

Additional Orders: \_\_\_\_\_

**D** Choose One

**SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:**

Patient or  Legally Authorized Representative (LAR). If LAR is checked, you **must** check one of the boxes below:

<input type="checkbox"/> Guardian	<input type="checkbox"/> Agent designated in Power of Attorney for Healthcare	<input type="checkbox"/> Patient-designated surrogate
<input type="checkbox"/> Surrogate selected by consensus of interested persons (Sign section E)		<input type="checkbox"/> Parent of a Minor

**Signature of Patient or Legally Authorized Representative** My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.

Signature (required)	Name (print)	Relationship (write 'self' if patient)
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**Signature of Provider (Physician/APRN/PA licensed in the state of Hawai'i.)** My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Provider Name	Provider Phone Number	Date
Provider Signature (required)	Provider License #	
Summary of Medical Condition	Official Use Only	

## HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Patient Name (last, first, middle)		Date of Birth	Gender
<b>Patient's Preferred Emergency Contact</b> (Listing a person here does not make them a Legally Authorized Representative. Only an Advance Directive or state law grants that authority.)			
Name	Relationship to Patient	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Form Prepared

### **E** SURROGATE SELECTED BY CONSENSUS OF INTERESTED PERSONS (Legally Authorized Representative as outlined in section D)

I make this declaration under the penalty of false swearing to establish my authority to act as the legally authorized representative for the patient named on this form. The patient has been determined by the primary physician to lack decisional capacity and no health care agent or court appointed guardian or patient-designated surrogate has been appointed or the agent or guardian or designated surrogate is not reasonably available. The primary physician or the physician's designee has made reasonable efforts to locate as many interested persons as practicable and has informed such persons of the patient's lack of capacity and that a surrogate decision-maker should be selected for the patient. As a result I have been selected to act as the patient's surrogate decision-maker in accordance with Hawai'i Revised Statutes §327E-5. I have read section C below and understand the limitations regarding decisions to withhold or to withdraw artificial hydration and nutrition.

Signature (required)	Name	Relationship
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### DIRECTIONS FOR HEALTH CARE PROFESSIONAL

#### Completing POLST

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a Physician, Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) licensed in the state of Hawai'i and the patient or the patient's legally authorized representative to be valid. Verbal orders by providers are not acceptable.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.
- The most recently completed valid POLST form supersedes all previously completed POLST forms. This form does not expire.

**Using POLST** - Any incomplete section of POLST implies full treatment for that section.

#### Section A:

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "No CPR. Do Not Attempt Resuscitation"

#### Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort-Focused Treatment", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort-Focused Treatment."
- A person who desires IV fluids should indicate "Selective Treatment" or "Full Treatment."

#### Section C:

- A patient or a legally authorized representative may make decisions regarding artificial nutrition or hydration. However, a surrogate who has not been designated by the patient (surrogate selected by consensus of interested persons) may only make a decision to withhold or withdraw artificial nutrition and hydration when the primary physician and a second independent physician certify in the patient's medical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future. HRS §327E-5.

**Reviewing POLST** - It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

#### Modifying and Voiding POLST

- A person with capacity or, if lacking capacity the legally authorized representative, can request a different treatment plan and may revoke the POLST at any time and in any manner that communicates an intention as to this change.
- To void or modify a POLST form, draw a line through Sections A through E and write "VOID" in large letters on the original and all copies. Sign and date this line. Complete a new POLST form indicating the modifications.
- The patient's provider may medically evaluate the patient and recommend new orders based on the patient's current health status and goals of care.

### Kōkua Mau - A Movement to Improve Care

Kōkua Mau is the lead agency for implementation of POLST in Hawai'i. Visit [kokuamau.org/polst](http://kokuamau.org/polst) to download a copy or find more POLST information. This form has been adopted by the Department of Health May 2023  
Kōkua Mau • PO Box 62155 • Honolulu HI 96839 • [info@kokuamau.org](mailto:info@kokuamau.org) • [kokuamau.org](http://kokuamau.org)

**SEND THIS 2-PAGE FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED POLST pg 2 of 2**



## Respiratory Infection Policy

Dear clients, caregivers, and visitors –

In accordance with CDC guidance, we are asking all visitors to monitor for signs and symptoms of respiratory infection for at least 14 days after exiting the facility. If symptoms occur, you are advised to self-isolate at home, contact your healthcare provider, and immediately notify the facility of the date that you started experiencing symptoms, and who you were in contact with while in the facility.

While in the facility, please adhere to the following requirements:

- Limit movement within the facility, minimize walking in the halls, and avoid common areas.
- Practice hand hygiene before and after your visit and as indicated while you are in the building.
- A mask must be worn at the screen station and should remain on during the duration of the visit. Avoid touching the front of the mask while you have it on.
- Wear any additional personal protective equipment as directed by staff before entering the facility.
- Avoid touching surfaces in the facility.
- Maintain a social distance from participants and staff (minimum 6 feet) and avoid contact as much as possible.

Acknowledgment of understanding:

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Name of Participant

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Signature of Participant or Responsible Party

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Date



## **CLIENT'S RIGHTS**

Written policies regarding the rights and responsibilities of clients during their stay at the center have been established and shall be made available to you and your guardian, next of kin, sponsoring agency or representative payee, and the public. The center's policies and procedures shall provide that each individual admitted to the center shall be provided:

### **1. Dignity & Respect**

- a. Not be humiliated, harassed, injured, or intimidated and shall be free from chemical and physical restraints. Physical restraints may be used only in an emergency when necessary to protect the client from injury to the client and others. In such an event, the client's physician shall be notified as soon as possible, and further order obtained, as provided in the Hawaii Administrative Rules Title 11, Department of Health, Chapter 96. Freestanding Adult Day health Center; and
- b. Be treated with consideration, respect, and in full recognition of their dignity and individuality, including privacy in treatment and in care as appropriate.

### **2. Ready Access to Information**

- a. Be fully informed, as evidenced by the client's written signed acknowledgement prior to or at the time of admission of these rights and of all rules governing client conduct;
- b. Be fully informed, prior to or at the time of admission and during stay, of services available in or throughout the center and of related charges, including any charge for services not covered by the center's basic per diem rate;
- c. Be advised that clients have a right to have their medical condition and treatment discussed with them by a physician of their choice, and to be afforded the opportunity to participate in the planning of their medical treatment and to refuse to participate in experimental research;
- d. Be encouraged and assisted throughout their period of stay to exercise their rights as clients, and to this extent to have grievances and to recommend changes in policies and services to the center's and outside representatives of their choice free from restraint, interference, coercion, discrimination, and/or reprisal.

**3. Freedom of Choice**

- a. Have the right to refuse treatment after being informed of the medical benefits of treatment, the consequences of refusal, and the medical alternatives;
- b. Not be required to perform services for the center that are not included for therapeutic purposes in their plan of care;
- c. Be allowed to end participation at the Adult Day Health center at any time;
- d. Have reasonable access to telephones, both to make and receive calls, or to have such calls made for the client, if necessary.

**4. Grievance Procedures**

- a. Each center shall have a formal fair hearing written procedure for any alleged client's rights infractions;
- b. The center shall provide for and encourage each employee to report observations or evidence of abuse.

**5. Privacy and Confidentiality**

- a. Be entitled to have their personal and health records kept confidential and subject to release only as provided in the Hawaii Administrative Rules, Title 11, Department of Health, chapter 96, Freestanding Adult Day Health Centers.

**6. Admissions and Discharge**

- a. Be discharged only for medical reasons, or for the client's welfare or that of other clients, or for non-payment for services, and be given reasonable advance notice to ensure orderly discharge. Such actions shall be documented in the client's records.

# Adult Day Health



## A CAREGIVER'S PLEDGE

1. I will understand that I can't care for anyone else if I also don't care for myself. I will keep an image in my mind of putting the oxygen mask on myself first.
2. I will remember that the only person I can change is myself. I cannot change my loved one who is ill, not my family members.
3. I will find opportunities to laugh daily. These might come in movies, jokes, television, or with friends who can see the humor in my situation and remind me to do the same.
4. I will get away from my caregiving duties on a regular basis, even if it is just to walk around the block. I will also find ways to have lunch with a friend, go to a movie, window shop, breathe in fresh air, watch a sunset, or eat a hot fudge sundae.
5. I will visit a support group, either on-line (at [www.caregiver.org](http://www.caregiver.org) or Link2Care) or in person in my community, so that I know that I am not alone. If a support group isn't right for me, I will find a friend to talk to, call my family consultant, or attend a workshop.
6. I will learn as much as I can about my loved one's illness so that I can better care for him or her with understanding. I will learn techniques that will make care giving easier for both of us.
7. I will say "yes" when people offer to help. I will make a list of things that they can do and post it on the refrigerator, so that when those offers come, I'll be ready. When there are not offers, I will ask for help, even though it may be hard to do so.
8. I will use community resources – such as Meals on Wheels, paratransit, day care programs, and volunteer respite programs – to help make my caregiving duties easier.
9. I will find something I really like to do and make sure I find time to do it on a regular basis. Just because I am a caregiver, doesn't mean I have to give up everything that is meaningful to me. I will read, knit, garden, scrapbook, do genealogy or wood working for a designated period of time every week.
10. I will remember that I am loved and appreciated, even when my loved one can't tell me that. I will honor the nurturing, responsibility, caring, and support that I provide to my loved one as a gift of my love.

**JOINT NOTICE OF PRIVACY PRACTICES  
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED  
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION**

Effective Date Of This Notice: <u>February 12, 2026</u>
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**PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this Notice, please contact our Privacy Officer, who may be reached at 45-181 Waikalua Road, Kaneohe, HI 96744, Phone: (808) 562-3796.

**WHO WILL FOLLOW THIS NOTICE**

This Notice describes the privacy practices at Ohana Pacific Health (“OPH”) facilities and of OPH service providers that are designated as a single “affiliated covered entity” under the federal law known as the Health Insurance Portability and Accountability Act (“HIPAA”). The entities and providers that are included may be found at the following link: [www.ohanapacific.com](http://www.ohanapacific.com). This Notice also applies to and will be followed by:

- The health care providers, such as physicians, nurses, or other clinical staff who provide services at an OPH facility or for an OPH service provider, whether or not they are employed by the facility or the OPH service provider; and
- Other persons who are employed by or work at OPH facilities or for an OPH service provider.

All of these persons are referred to as “we” or “us” in this Notice.

**OUR PLEDGE REGARDING YOUR HEALTH INFORMATION**

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you in accordance with the requirements of HIPAA. We will create a record of the care and services you receive from us. Your protected health information (“PHI”) is health information that contains identifiers, such as your name, e-mail address, Social Security number, or other information that reveals who you are. For example, your medical record is PHI because it includes your name and other identifiers. This Notice applies to all of the PHI we generate or receive about you, whether we documented the PHI or another provider sent it to us. This Notice will tell you the different ways we may use or disclose PHI about you. This Notice also describes your rights regarding the PHI we keep about you and describes certain obligations we have regarding the use and disclosure of your PHI.

In addition to protecting the privacy and security of your PHI, HIPAA requires us to notify you of our legal duties and privacy practices with respect to PHI about you; to notify you in the event there is a breach of your unsecured PHI; and to follow our Notice of Privacy Practices currently in effect.

**HOW WE MAY USE AND DISCLOSE PHI ABOUT YOU**

The following categories describe different ways that we may use or disclose PHI about you. Unless otherwise noted, each of these uses and disclosures may be made without your specific permission. For each category of use or disclosure, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, unless we ask you for a separate authorization, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment.** We may use PHI about you to provide you healthcare treatment and services. We may disclose PHI about you to doctors, nurses, technicians, health students, volunteers or other personnel who are involved in taking care of you. For example, a doctor treating you at another facility may need to know if you have diabetes or other conditions, so we may provide that information to the doctor.

**For Payment.** We may use and disclose PHI about you so that the services you receive from us may be billed to and payment collected from you, an insurance company, a state Medicaid agency or another third party. For example, we may need to give your health insurer or Medicare or QUEST information about your treatment so we can be paid for our care or receive prior approval for your care.

**For Healthcare Operations.** We may use and disclose PHI about you for our healthcare operations, as appropriate to run our operations and make sure that our patients receive quality care. For example, we may use PHI to review our treatment and services, for quality and utilization purposes, to obtain legal advice, or to evaluate the performance of our staff in caring for you.

**Directory (as available).** Unless you object, we will include certain limited information about you in the facility's directory while you are an inpatient at our facility. This information may include your name, location in the facility, your general condition (fair, stable, etc.), and your religious affiliation. With the exception of your religious affiliation, the directory information may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. If you do not want this information listed in the directory, you must notify the Administrator.

**Individuals Involved in Your Care or Payment for Your Care and Notification.** Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, information that directly relates to that person's involvement in your health care. We also may give information to someone who helps pay for your care. In addition, we may disclose PHI about you to disaster relief agencies, such as the Red Cross, so that your family can be notified about your condition, status, and location. We also may share PHI with these people to notify them about your location and general condition. You can object to these releases by telling us that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot object, we will use our professional judgment to determine whether the disclosure is in your best interests and whether the person may act on your behalf to pick up filled prescriptions, medical supplies, x-rays, or other similar items.

**Research.** We may use and disclose PHI about you for research purposes, for example, to compare the effectiveness of one medication over another. Health information about you that has had identifying information removed may be used for research without your consent. If any research project uses your PHI, we will either obtain an authorization directly from you or obtain a waiver of the authorization requirement from an Institutional Review or Privacy Board based on assurances that the researchers will adequately protect your PHI.

**As Required By Law.** We will disclose PHI about you when required to do so by federal, state, or local law, such as in compliance with a court order requiring us to do so.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. For example, if you threaten violence to a family member, we may report information to the police to allow them to protect the family member.

**Active Duty Military Personnel and Veterans.** If you are an active duty member of the armed forces or Coast Guard, we must give certain information about you to your commanding officer or other command authority so that your fitness for duty or for a particular mission may be determined. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may use and disclose to components of the Department of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.

**Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Public Health Activities.** We may disclose PHI about you for public health activities. These activities generally include preventing or controlling disease, injury, or disability; reporting births, deaths, child or vulnerable adult abuse or neglect, domestic violence or other violent injuries, reactions to medications or product injuries or recalls; and for organ or tissue donation.

**Judicial and Administrative Proceedings.** If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to an order issued by a court or administrative tribunal; or pursuant to a legally authorized request, such as a subpoena, discovery request, or other lawful process, so long as the person requesting the information has complied with HIPAA requirements to notify you and provide you a reasonable time for objections, or has made reasonable efforts to obtain an order protecting the information requested.

**Law Enforcement Purposes.** We may release PHI if asked to do so by a law enforcement official:

- in response to a court order or court-ordered subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death or injury we believe may be the result of criminal conduct;
- about suspected criminal conduct at OPH or on OPH property; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

**Coroners, Health Examiners and Funeral Directors.** We may release PHI to a coroner or health examiner if necessary to identify a deceased person or determine the cause of death, or to funeral directors as necessary to carry out their duties.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official, if such information is necessary for the institution to provide you with healthcare or to protect your health and safety or the health and safety of others.

**Marketing.** Most uses and disclosures of your PHI for marketing purposes require your prior written authorization.

**Psychotherapy Notes.** Most uses and disclosures of psychotherapy notes require your prior written authorization.

**Sale of Your PHI.** We do not sell your PHI. If in the future we decide to sell your PHI, we would obtain your written authorization before doing so.

**Fundraising.** We may use certain information about you (name, address, telephone number, dates of service, age, and gender) to contact you in the future to raise money for OPH, but if we do this we will provide you a way to opt out of such communications. Even if you have opted out, we may send you non-targeted fundraising materials that we send out to the general community and that are not based on information we have obtained from your treatment.

**Transitions of Care.** When working with other health care providers such as local hospitals, physician offices and other skilled nursing facilities, we will securely send your health information electronically through private networks. This technology allows us to send continuity of care documents, care summaries, lab results and more to help ease transitions of care.

**Health Information Exchanges.** We participate in one or more Health Information Exchanges (“HIEs”), including the Hawai‘i Health Information Exchange (Hawai‘i HIE). These exchanges allow health care providers and organizations to securely share your health information electronically to improve the quality, safety, and coordination of your care. Your health information may be shared through an HIE with other providers involved in your care, unless you choose to opt out.

If you do not want your health information to be viewable through the Hawai‘i HIE Health eNet Community Health Record (“CHR”), you must complete a Request to Stop Individual Participation form, available at [www.hawaiihie.org](http://www.hawaiihie.org). Submit the completed form to your health care provider, who will forward it to Hawai‘i HIE. Your request will be processed within 10 business days, and you will receive confirmation from Hawai‘i HIE. Even while opted out, your health information may still be contributed to the CHR but will not be viewable by providers (including emergency room physicians). You may opt back in at any time by submitting a Request to Resume Individual Participation form. For questions or assistance, contact Hawai‘i HIE at (808) 441-1374 or visit their [Policies page](#).

## **HOW WE MAY USE AND DISCLOSE YOUR SUBSTANCE USE DISORDER DIAGNOSIS & TREATMENT RECORDS**

Any records we receive or maintain containing information about your diagnosis or treatment for a substance use disorder (“SUD”) are subject to additional protections under 42 CFR Part 2 (“Part 2”). We may only disclose information relating to your SUD diagnosis or treatment (“Part 2 Records”) in the following scenarios:

### **Without Your Consent.**

- **Medical Emergency:** We may use or disclose your Part 2 Records to health care providers when it is necessary to meet a bona fide medical emergency and your prior written consent cannot be obtained. We also may disclose your Part 2 Records to medical personnel at the United States Food and Drug Administration (“FDA”) who state a reason to believe that your health may be threatened by an error in the manufacture, labeling, or sale of a product under FDA authority, but the FDA will use your information solely to notify you or your providers of potential dangers. We will document any such disclosures in your medical record.
- **Court Order with Compulsory Process:** We may disclose your Part 2 Records in response to a special court order that complies with the requirements of 42 CFR Part 2, Subpart E and is accompanied by a subpoena or similar legal mandate that requires the use or disclosure.
- **Research:** We may use or disclose your Part 2 Records for research purposes if we determine that one or any combination of the following is true:
  - The recipient of the information is a covered entity or business associate as those terms are defined under HIPAA, and a patient authorization has been obtained or the authorization requirement has been waived under HIPAA; or
  - The research is conducted in accordance with the Department of Health and Human Services policy on the protection of human subjects research (45 CFR Part 46); or
  - The research is conducted in accordance with the FDA requirements regarding the protection of human subjects research (21 CFR Parts 50 and 56).
- **Audit & Evaluation Activities:** We may use and disclose your Part 2 Records for auditing or evaluation activities that are performed on behalf of: any federal, state or local government; any third-party payer or health plan that provides insurance coverage to patients in a Part 2 program; a quality improvement organization or their contractors; or any entity with direct administrative control over a Part 2 program. These disclosures will be made in accordance with the requirements of 42 CFR § 2.53.

- **Public Health:** We may disclose your de-identified Part 2 Records for public health purposes to a public health authority pursuant to 42 CFR § 2.54.
- **Commission of Crime:** We may disclose your Part 2 Records to law enforcement if information in your records directly relates to (1) your commission of a crime on OPH property or against an OPH employee, or (2) your threat to commit such a crime. Any disclosure for this purpose will be limited to circumstances of the incident, your name, address, and last known whereabouts.
- **Child Abuse/Neglect:** We may disclose your Part 2 Records when the law requires us to report incidents of suspected child abuse or neglect to the appropriate state or local authorities. However, without your consent we may not disclose your Part 2 Records as part of any civil or criminal proceeding against you that may arise from a report of suspected child abuse or neglect.
- **Fundraising:** We may use Part 2 Records about you to contact you in an effort to raise money for OPH to support our services. Before using or disclosing your Part 2 Records in this way, we will provide you with an opportunity to opt out of receiving this type of communication.

### **With Your Consent.**

- **Pursuant to Consent:** If we have received your Part 2 Records pursuant to your written consent, we may disclose those Part 2 Records without your written consent as permitted by HIPAA, except as described below.
- **Civil, Criminal, Administrative, or Legislative Proceedings Against You:** If we receive your specific written consent or a court order, we may use and disclose your Part 2 Records in connection with any civil, criminal, administrative, or legislative proceeding brought against you. Your records will only be used or disclosed based on a court order (1) if the court order authorizing the use or disclosure of your records is accompanied by a subpoena or similar legal mandate compelling the disclosure, and (2) after notice of the order and an opportunity to object is provided.

### **YOUR RIGHTS REGARDING YOUR PHI AND PART 2 RECORDS**

You have the following rights regarding PHI and Part 2 Records we maintain about you:

**Right to Inspect and Copy.** You have certain rights to inspect and copy PHI or Part 2 Records that may be used to make decisions about your care (such as health and billing records), to the extent provided by law. This does not include psychotherapy notes or other records covered by a separate legal privilege or other legal protection. To inspect and copy PHI, your request must be in writing on a form provided by or agreeable to us and submitted to the facility's or other OPH service provider's Administrator or our Privacy Officer. We may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request, in accordance with applicable law. For any electronic health records we maintain about you, you may request that we provide the information in paper format or electronic format and that we provide the copy to you or to another person. We may charge a reasonable fee for the cost of providing electronic information you request, not greater than our labor costs in responding to the request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed. Another licensed health care professional chosen by OPH will review your request and the denial. The person conducting the review will not be the person who denied your initial request. We will do what this reviewer decides.

**Right to Amend.** If you believe PHI we keep about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing on a form provided by us and submitted to the facility's or other OPH service provider's Administrator or our Privacy Officer. We may deny your request for an amendment if the information was not created by us, unless the person who created the information is no longer available to make the amendment; if the information is not part of the PHI kept by or for OPH; if it is not part of the information which you would be permitted to inspect and copy; or if we determine the information is accurate and complete. If we deny your request for an amendment, you may submit a written

statement of disagreement and ask that it be included in your medical record. Any amendment we make to your PHI will be disclosed to those who need to know of the amendment, to the extent required by law.

**Right to an Accounting of Disclosures.** You have the right to request an accounting (a list) of any disclosures of your PHI and Part 2 Records we have made, except for uses and disclosures for treatment, payment, and health care operations. To request this list of disclosures, your request must be in writing on a form provided by us, and the form must be submitted to the facility's or other OPH service provider's Administrator or our Privacy Officer. Your request must state a time period that may not be longer than six years before the date of your request. If disclosures of your Part 2 Records were made through an electronic health record, this accounting will include disclosures we made for the purposes of treatment, payment, and health care operations for the past three years. The first accounting of disclosures you request within a 12-month period will be free. We may charge you for the costs of providing additional accountings within that period, but we will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will provide you an accounting of disclosures within 30 days of your request, or notify you if we are unable to supply the accounting within that time period and by what date we can supply the accounting, not to exceed a total of 60 days from your request.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the PHI or Part 2 Records we use or disclose about you (1) for treatment, payment, or health care operations, or (2) to someone who is involved in your care or the payment for your care. While we may accommodate reasonable requests for restrictions, we are not required to do so (for example, if it is not feasible for us to ensure our compliance with law or we believe it will negatively impact the care we may provide you). If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing on a form provided by or agreeable to us, and submit the form to the facility's or other OPH service provider's Administrator or our Privacy Officer. In your request, you must tell us what information you want to limit and to whom you want the limits to apply. You also have the right to request a restriction on the PHI or Part 2 Records we may disclose to your health plan about the care or services you receive from us, so long as you (or anyone other than your health plan) have paid in full for that care or those services at the time services are rendered. We are required to, and will, comply with any such request.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain manner or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box. During our intake process, we will ask you how you wish to receive communications about your health care or for any other instructions on notifying you about your PHI. We will accommodate all reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to obtain a paper copy of this Notice at any time upon request, even if you have previously agreed to receive an electronic copy of the Notice. You may also obtain a copy of this Notice on our website at [www.ohanapacific.com](http://www.ohanapacific.com).

## **MINORS AND PERSONS WITH GUARDIANS**

Married minors have all the confidentiality rights outlined in this Notice. Unmarried minors who are at least 14 years old have all the confidentiality rights outlined in this Notice regarding health care they obtain relating to treatment of venereal disease, pregnancy and family planning services, and SUD counseling. Minors who are at least 14 years old and who do not have the support of a parent or guardian also have all the rights outlined in this Notice regarding primary care services they obtain. Except as described in this section, for unmarried minors and persons with a legal guardian, a parent or legal guardian generally has the right to access the medical record of the minor or ward and make certain decisions regarding the uses and disclosures of that information, in accordance with applicable law.

**Changes to This Notice.** We reserve the right to change this Notice and to make the changed Notice effective for PHI and Part 2 Records we already have about you as well as any information we receive in the future. If we make an important change to our privacy practices, we will promptly change this Notice and the new Notice will be posted at the facility or other OPH service provider's office and on our website. A paper or electronic copy of

the revised Notice will be distributed to new patients at our facility or of our other OPH service providers and will be available to you upon request.

**Investigations of Breaches of Privacy.** We will investigate any discovered unauthorized use or disclosure of your health information or Part 2 Records to determine if it constitutes a breach of the federal privacy or security regulations addressing such information. If we determine that such a breach has occurred, we will provide you with notice of the breach and advise you what we intend to do to mitigate the damage (if any) caused by the breach, and about the steps you should take to protect yourself from potential harm resulting from the breach.

### **Complaints**

If you have a complaint about your privacy rights or our privacy and security practices or breach notification procedures, you may file a complaint with us (contact our Privacy Officer at the address or telephone number listed at the top of this Notice). You also may send a complaint to Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F HHH Bldg., Washington D.C. 20201, or you may email a complaint to [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov). **You will not be penalized for filing a complaint.**

### **Other Uses of PHI**

Other uses and disclosures of PHI or Part 2 Records not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us authorization to use or disclose PHI or Part 2 Records about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose PHI or Part 2 Records about you for the reasons covered by your written authorization. However, you should understand that we are unable to take back any disclosures we have already made, and that we are required to retain the records of the care that we provided to you.

### **Participants in the OPH Affiliated Covered Entity**

For the list of participants, go to [www.ohanapacific.com](http://www.ohanapacific.com)

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**JOINT NOTICE OF PRIVACY PRACTICES**

**Participants in the OPH Affiliated Covered Entity**  
**(as of November 5, 2025)**

1. Ann Pearl Care Home, LLC dba Ann Pearl Rehab. and Healthcare
2. Integrated Health Resources, LLC dba Puuwai O Makaha
3. Liliha Kupuna SNF, LLC dba The Villas
4. Garden Isle Healthcare, LLC dba Garden Isle Rehab & Healthcare
5. Hale Kupuna Heritage Home, LLC dba Hale Kupuna Heritage Home
6. Hilo SNF, LLC dba Legacy Hilo Rehabilitation & Nursing
7. Prime Care Services Hawaii, LLC dba Home Health Honolulu
8. Stay at Home Healthcare Services, LLC dba Home Health Kauai
9. Stay at Home Healthcare Services, LLC dba Home Health Hawaii Island
10. Kalele Care Services, LLC dba Kalele Care Services
11. Hale Makua Health Services
12. Hawaii Health Systems Corporation – Oahu Region relating to Daniel K. Akaka State Veterans Home
13. Ohana Pacific Foundation operating as Kauai Adult Day Health

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## Discrimination is Against the Law

OHANA PACIFIC HEALTH and ITS COVERED FACILITIES comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Our covered facilities:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need any of these services, contact our Civil Rights Coordinator at:  
[civilrightscoordinator@ohanapacific.com](mailto:civilrightscoordinator@ohanapacific.com) or (808) 562-3755.

If you would like to file a grievance or complaint, you may contact our Civil Rights Coordinator at [civilrightscoordinator@ohanapacific.com](mailto:civilrightscoordinator@ohanapacific.com) OR 45-181 Waikalua Road, Kaneohe, Hawaii 96744 OR (808) 562-3755. You can file a grievance by email or mail or in person. Our Civil Rights Coordinator is available to help you with filing a grievance.

You can also file a civil rights complaint with the U.S. Dept. of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019 (phone) or 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Attention:** If you speak a foreign language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-808-562-3755 or speak to your provider.

**繁體中文 (Chinese-Cantonese/Mandarin):** 注意：如果您說中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-808-562-3755 或與您的提供者討論。

**한국어 (Korean):** 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-808-562-3755번으로 전화하거나 서비스 제공업체에 문의하십시오.

**Tiếng Việt (Vietnamese):** LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-808-562-3755 hoặc trao đổi với người cung cấp dịch vụ của bạn.

**Ilokano (Ilocano):** PANANGIKASO: No agsasaoka iti Ilocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-akses a pormat. Awagan ti 1-808-562-3755 wenno makisarita iti mangipapaay kenka.

**Foosun Chuuk (Chuukese/Trukese):** ESINESIN: Ika en mi kan fos non Chuukese, mi kawor aninisin awewen fos ese kamo ngonuk. Mi pwan kawor aninisin ousening me aninisin maken non och nikinik epwe mecheres ngonuk ese kamo. Kekeri 1-808-562-3755 ika fos ngeni noumw ewechon awora aninis.

**日本語 (Japanese):** 注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-808-562-3755 までお電話ください。または、ご利用の事業者にご相談ください。

**Tagalog (Tagalog – Filipino):** PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-808-562-3755 o makipag-usap sa iyong provider.

**Kajin Majōl (Marshallese):** IKIJEN: Ne kwōj kajin Majol, ewōr jibañ ejellok wonnen ñan kwe ilo kajin eo am. Ebar wōr kein roñjak im jibañ ko rekkar ñan lewaj melele ilo wāween ko kwōmaron loi im ejellok wonnen. Kall ae lok 1-808-562-3755 ñe ejab kenono ibben armij ak opij eo ej lewaj jermal in jjibañ ñan kwe.

**Gagana fa’a Sāmoa (Samoan):** MAITAU MAI: Afai e te tautala (Samoa), e avanoa le auaunaga fai fua i lea gagana mo oe. Fesoasoani i ausilali ma auaunaga talafeagai e tu’uina atu fa’amatalaga i fola avanoa ma maua gofie e leai se totogi. Vala’au le 1-808-562-3755 pe talanoa i lau tagata fa’atonu.

**Tonga (Tongan):** FAKATOKANGA: ‘O kapau ‘oku ke lea[Lea faka-Tonga], ‘oku ‘i ai e tokotaha ke tokoni ta’etotongi atu he lea koia. Oku ‘i ai e ngaahi me’a ngaue mo e ngaahi ngaue kene ‘omai ha ngaahi fakamatala pea ‘i ha founga faingofua pea ‘oku ma’u ta’etotongi foki. Telefoni ki he 1-808-562-3755 pe lea ki ho’o kautaha.

**Español (Spanish):** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-808-562-3755 o hable con su proveedor.

**Lokaiahn Pohnpei (Pohnpeian/Micronesian):** MEHN KAPEHSE: Mah ke kin Lokaiahn Pohnpei, mie sahpis en kawehwe lokaia kin kohda ni sohte pweipwei ohng kowe. Mehn sawas teikan oh sahpis ohng kihda mengihtik ni soangen mwowhmw teikan kak kohda ni sohte pweipwei. Eker 1-808-562-3755 de lokaiahng noumw soun sawas.

**ພາສາລາວ (Loatian/Lao):** ເຊີ ນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີ ບໍລິ ການຊ່ວຍດ້ານພາສາແບບບໍ່ ເສຍຄ່າໃຫ້ທ່ານ. ມີ ເຄື່ອງ ຊ່ວຍ ແລະ ການບໍລິ ການແບບບໍ່ ເສຍຄ່າທີ່ ເໝາະສ ມເພື່ອ ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-808-562-3755 ຫລື ມາຮູ້ ໃຫ້ບໍລິ ການຂອງທ່ານ.

**Bisaya (Bisayan/Visayan):** PAGTAGAD: Kung nagsulti ka [og Bisaya], magamit nimo ang libre nga serbisyo sa pagtabang sa sinultian. Ang angay nga mga pangtabang ug mga serbisyo aron mahatagan ang kasayuran sa ma-access sa mga format magamit usab nga wala’y bayad. Tawag sa 1-808-562-3755 o pakigsulti sa imong tighatag.

**Ho’okomo ‘ōlelo (Hawaiian):** MANA’O: Inā ‘oe e ‘ōlelo [‘Ōlelo Hawai’i], loa‘a iā ‘oe nā lawelawe kōkua ‘ōlelo manuahi. Loa‘a ‘ia nā kōkua kōkua kūpono a me nā lawelawe e hā‘awi i ka ‘ike ma nā palapala hiki ke loa‘a me ka uku ‘ole. E kelepona iā 1-808-562-3755 a i ‘ole e kama‘ilio me kāu mea ho‘olako.



### Application and Admission Checklist

Participant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Contact Numbers: \_\_\_\_\_(home) \_\_\_\_\_(work)

Email: \_\_\_\_\_

Days Attending (Circle Specific Days): M T W TH F

Times Attending (please specify time): \_\_\_\_\_AM to \_\_\_\_\_PM

Please **initial** as evidence of approval:

\_\_\_\_\_ I authorize Kauai Adult Day Health Center staff to provide emergency medical care as needed (within constraints of my Advance Directive).

\_\_\_\_\_ I have received a copy of the Kauai Adult Day Health Center Admission Agreement and understand it.

\_\_\_\_\_ I have received a copy of "Clients Rights" and understand it.

\_\_\_\_\_ I have received a copy of "OPH Notice of Privacy Practices" and understand it.

\_\_\_\_\_ I have received a copy of "OPH Notice of Nondiscrimination" and understand it.

\_\_\_\_\_ I have received a copy of "Client Responsibilities" and understand it.

\_\_\_\_\_ I have a received a copy of the "Advance Health Care Directive" form and understand Advance Directives.

\_\_\_\_\_ I have Advance Health Care Directives (circle one: Yes or No)

\_\_\_\_\_ I understand that a physical examination and TB Test is required annually by the State of Hawaii licensing regulations

\_\_\_\_\_ I understand that my photograph and/or video recordings may be used from time to time to promote community-based day services for the elderly.

\_\_\_\_\_ I understand that information may be shared with the Office of  
Community Assistance - Agency of Elderly Affairs.

\_\_\_\_\_ I have received a copy of the Kauai Adult Day Health Center's Fee  
Schedule.

\_\_\_\_\_ I understand that fees will be billed in advance at the end of the  
previous month with payment due by the 20<sup>th</sup> of each month.

My signature acknowledges that it is my choice to attend Kauai Adult Day Health Center  
and understand the above-mentioned items as explained to me by the Day Health Staff.

\_\_\_\_\_  
Signature (or mark) of Client                      Date

\_\_\_\_\_  
Witness, if signature is an "X"

\_\_\_\_\_  
Signature of Guardian or next of kin                      Date

\_\_\_\_\_  
Relationship

Dear Participant or Guardian:

The CACFP offers meal reimbursements to adult day care facilities which provide structured comprehensive services to nonresidential adults who are functionally impaired, or aged 60 and older. By completing the attached Meal Benefit Income Eligibility Form, the centers will be able to receive reimbursement, which is based on the number of enrolled participants that are eligible for free or reduced price meals.

**1. Do I need to fill out a Meal Benefit Form for each adult in day care? You may** complete and submit one CACFP Meal Benefit Income Eligibility Form for the adults enrolled in day care in your household **only** if they are enrolled in the same center. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. **Return the completed form to: Kaua'i Adult Day Health Center, 2943 Kress Street, Lihue, HI 96766. Phone: (808) 246-6919.**

**2. Who can get free meals?** Adults in households getting Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamp), Supplemental Security Income (SSI) or Medicaid benefits can get free meals.

**3. Who can get reduced price meals?** Adults can get low cost meals if your household income is within the reduced price limits on the Federal Income Chart, shown on this application.

**4. May I fill out a form if someone in my household is not a U.S. citizen?** Yes. You or the adult in your care do not have to be U.S. citizens to qualify for meal benefits offered at the center.

**5. Who should I include as members of my household?** You must only include the adult in your care, his or her spouse, and his or her dependents who share income and expenses.

**6. How do I report income information and changes in employment status?** The income you report must be the total gross income listed by source for each household member received last month. If last month's income does not accurately reflect your circumstances, you may provide a projection of your monthly income. If no significant change has occurred, you may use last month's income as a basis to make this projection. If your household's income is equal to or less than the amounts indicated for your household's size on the attached Income Chart, the adult day care will receive a higher level of reimbursement. Once properly approved for free or reduced price benefits, whether through income or proof of benefits as supported by a current SNAP case number or a SSI or Medicaid assistance number, you will remain eligible for those benefits for a period not to exceed 12 months. You should, however, notify us if you or someone in your household becomes unemployed and the loss of income during the period of unemployment causes your household income to be within the eligibility standards.

**7. What if my income is not always the same?** List the amount that you normally get. For example, if you normally get \$1000 each month, but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but do not include it if you only work overtime sometimes. If you have lost a job or had your hours or wages reduced, use your current income.

**8. We are in the military, do we include our housing allowance as income?** If your housing is part of the Military Housing Privatization Initiative and you receive the Family Subsistence Supplemental Allowance, do not include these allowances as income. Also, in regard to deployed service members, only that portion of a deployed service member's income made available by them or on their behalf to the household will be counted as income to the household. Combat Pay, including Deployment Extension Incentive Pay (DEIP) is also excluded and will not be counted as income to the household. All other allowances must be included in your gross income.

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident. Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, [AD-3027](#), found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **Mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410;
2. **Fax:** (202) 690-7442; or
3. **Email:** [program.intake@usda.gov](mailto:program.intake@usda.gov).

This institution is an equal opportunity provider.

If you have other questions or need help, call **Kaua'i Adult Day Health Center: (808) 246-6919.**

Sincerely,  
Kim Sueoka, Program Director, Kaua'i Adult Day Health

**INSTRUCTIONS FOR COMPLETING  
BENEFIT INCOME ELIGIBILITY ADULT DAY CARE CENTERS**

**Follow these instructions, if your household gets Supplemental Nutrition Assistance Program (SNAP), or Supplemental Security Income (SSI) or Medicaid:**

**Part 1:** List participant's name and a SNAP, SSI, or Medicaid case number.

**Part 3:** Sign the form. The last 4 digits of your Social Security Number is not necessary.

**Part 4:** Answer the participant's ETHNIC and RACIAL Identities.

**ALL OTHER HOUSEHOLDS, follow these instructions:**

**Part 1:** List each participant's name.

**Part 2:** Follow these instructions to report total household income from last month.

**Column A–Name:** List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to.

**Column B–Gross income last month and how often it was received.** Next to each person's name, list each type of income received for the month, and how often it was received.

In Box 1, list the **gross income** each person earned from work, not take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).

In Box 2, list the amount each person got last month from welfare, child support, alimony, etc. In Box 3, list Social Security, pensions, and retirement.

In Box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, and regular contributions from people who do not live in your household. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. Do not include income from SNAP, WIC or Federal education benefits. If you are in the Military Housing Privatization Initiative or get combat pay, do not include this housing allowance.

**Column C–Check if no income:** If the person does not have any income, check the box.

**Part 3:** An adult household member must sign the form and list his or her last four digits of their Social Security Number, or mark the box if he or she doesn't have one.

**Part 4:** Declare participant's Ethnicity and Racial Identities. The information provide is solely for the purpose of determining compliance with federal Civil Rights Laws and will not affect eligibility.

**Privacy Act Statement:** This explains how we will use the information you give us.

**Non-discrimination Statement:** This explains what to do if you believe you have been treated unfairly.

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotope, American Sign Language, etc.) should contact the state or local agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, [AD-3027](#), found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **Mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410;
2. **Fax:** (202) 690-7442; or
3. **Email:** [program.intake@usda.gov](mailto:program.intake@usda.gov).

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# INSTRUCTIONS FOR COMPLETING BENEFIT INCOME ELIGIBILITY ADULT DAY CARE CENTERS

## Part 1. Participant enrolled to receive day care.

<b>Names</b> (First, Middle Initial, Last)	SNAP, SSI or Medicaid case number. <b>Skip to Part 3 if you listed a case #</b>

## Part 2. Total Household Gross Income—You must tell us how much and how often

A. Name (List <b>everyone</b> in household, including children)	B. Gross income and how often it was received <i>Example: \$100/monthly \$100/twice a month \$100/every other week \$100/weekly</i>				C. Check if <b>NO</b> income
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement,	4. All Other Income	
<i>(Example: Jane Smith)</i>	\$ <u>200</u> / <u>weekly</u>	\$ <u>150</u> / <u>weekly</u>	\$ <u>100</u> / <u>monthly</u>	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>
	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____	<input type="checkbox"/>

## Part 3. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list his or her last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

*I certify that all information on this form is true and that all income is reported. I understand that the center or day care home will get Federal funds based on the information I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.*

Sign here: X \_\_\_\_\_ Print name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Social Security Number: \_ \* \_ \* - \_ \* \_ - \_\_\_\_\_  I do not have a Social Security Number

## Part 4. Participant's ethnic and racial identities

Mark one ethnic identity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Mark one or more racial identities: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
---	---	---

## Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Annual Income: \_\_\_\_\_ Household size: \_\_\_\_\_

Eligibility Determination: Free \_\_\_\_\_ Reduced \_\_\_\_\_ Above Scale \_\_\_\_\_

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Income Guidelines for Reduced Priced Meals  
Effective July 1, 2025 to June 30, 2026**

**The participant in the day care facility may qualify for free or reduced-price meals if your household income falls within the limits on this chart.**

Household size	Yearly
1	\$33,282
2	\$44,992
3	\$56,703
4	\$68,413
5	\$80,124
6	\$91,834
7	\$103,545
8	\$115,255
Each additional person:	+\$11,711

**Privacy Act Statement:** The Richard B. Russell National School Lunch Act requires the information on this application. The information on the application is used only to determine eligibility for Fee or Reduced-Price meals and to verify eligibility.

You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you list a Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI) or Medicaid Case Number for the participant or other identifier or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced-price meals, and for administration and enforcement of the Program.

The information reported on this for is valid for one year.

Notify us if you or someone in your household becomes unemployed and the loss of income during the period of unemployment caused your household income to be within the eligibility guidelines.

# Enrollment Statement

## Child and Adult Care Food Program

Participant's Name  
is enrolled at:

Name of Center: Kaua'i Adult Day Health Center

Address: 2943 Kress Street, Lihue, HI 96766

Beginning on: \_\_\_\_\_  
Month/Day/Year

Participant's normal days and hours of care.	<b>**If attendance time and meals are the same Monday to Friday, fill in Monday and sign here.</b>  _____	Please circle meals Participant will participate in		
<b>Monday **</b>	_____ a.m. to _____ p.m. **	<b>Breakfast **</b>	<b>Lunch**</b>	<b>PM Snack**</b>
Tuesday	_____ a.m. to _____ p.m.	Breakfast	Lunch	PM Snack
Wednesday	_____ a.m. to _____ p.m.	Breakfast	Lunch	PM Snack
Thursday	_____ a.m. to _____ p.m.	Breakfast	Lunch	PM Snack
Friday	_____ a.m. to _____ p.m.	Breakfast	Lunch	PM Snack

<b>Mark one ETHNIC identity:</b>	<b>Mark one or more RACIAL identities:</b>
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American

Signature \_\_\_\_\_  
Participant/Guardian

Date \_\_\_\_\_

Signature \_\_\_\_\_  
Center Administrator

Date \_\_\_\_\_

In accordance with federal civil rights law and USDA civil rights regulations and policies, the USDA, its agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

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1. **Mail:** U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Mail Stop 9410, Washington, D.C. 20250-9410;
2. **Fax:** (202) 690-7442; or
3. **Email:** [program.intake@usda.gov](mailto:program.intake@usda.gov).

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For Center use only Participant withdrawn on



**TRANSPORTATION SERVICES WAIVER AND RELEASE**

Ohana Pacific Foundation dba Kauai Adult Day Health Center

Please read this form carefully and be aware that in consideration for Ohana Pacific Foundation dba Kauai Adult Day Health Center, you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you might sustain as a result of said services, including but not limited to, vehicle operations and boarding and exiting the vehicle.

I recognize and acknowledge that Kauai Adult Day Health Center is neither a common carrier nor in the business of providing transportation services to the public. I further recognize and acknowledge that there are certain risks of physical injury to vehicle passengers, and I voluntarily agree to assume the full risk of any injuries, damages or loss, regardless of severity, that I may sustain as a result of participating in any and all activities connected with or associated with receiving transportation services, including, but not limited to, injuries, damages and loss arising out of negligent operation or supervision of the vehicle. I further agree to waive and relinquish all claims I may have (or accrue to me) against Ohana Pacific Foundation dba Kauai Adult Day Health Center, including its respective officials, agents, volunteers, and employees (hereinafter collectively referred to as "Party").

I do hereby fully release and forever discharge the Party from any and all claims for injuries, damages or loss that I may have, or which may accrue to me and arising out of, connected with, or in any way associated with said transportation services.

I further agree that this agreement shall be governed by the laws of the State of Hawaii.

**I have read and fully understand the above waiver and release of all claims.**

**PLEASE PRINT**

**Participant's Name:**

\_\_\_\_\_

**Participant's signature:**

\_\_\_\_\_

(18 Years or Guardian)

**Date:** \_\_\_\_\_

**PARTICIPATION WILL BE DENIED**

If the signature of adult participant or guardian and date are not on this waiver.

# Adult Day Health



2943 Kress Street, Lihue, HI 96766 | Phone: (808) 246-6919 | www.ohanapacific.com/kauai-adult-day-health-center

## Consent and Authorization—Photos, Videos, Audio and Transcribed Statements (Advertising, Marketing and/or Promotion)

I, \_\_\_\_\_, give my permission for photos, videos, audio and/or transcribed statements (collectively “Multimedia”) to be taken of me by **Kaua’i Adult Day Health Center** staff and/or their representatives or affiliates and used for the purpose of advertising, marketing and/or promoting the Facility/Entity or Ohana Pacific Health and its programs. I agree that any Multimedia taken of me may be reproduced, published, and/or displayed for advertising, marketing, and promotional purposes, including providing the same to the general public and to media for the same purposes without further consideration or additional consent or authorization.

I understand that any Multimedia are the property of the Facility/Entity and will not be returned to me.

Such Multimedia may disclose the fact that I am or have been a resident or client of the Facility/Entity and may contain other information about me, including Protected Health Information.

I understand that (1) I am not required to sign this consent and authorization form, (2) signing this consent and authorization form is not a condition for treatment, payment, enrollment or eligibility for benefits, and (3) declining to consent or give authorization will not affect me receiving treatment or services nor will it affect payment or enrollment or eligibility for benefits.

I understand that information used or disclosed under this consent and authorization may be reused by the recipients and may no longer be protected by applicable law.

I understand that I may revoke this consent and authorization by notifying Facility/Entity in writing of my desire to revoke it. I understand that any action already taken in reliance on this consent and authorization cannot be reversed, and my revocation will not affect those prior actions. I understand that neither I nor Facility/Entity nor Ohana Pacific Health will receive payment for photographs or videos based on this consent and authorization.

This consent and authorization expires upon my discharge from the facility or termination of services. This expiration date does not affect my right to revoke this consent and authorization, as provided above, prior to the expiration date. I understand that the posting or publication of any Multimedia that was posted and/or published pursuant to this consent and authorization prior to the expiration date may continue to be posted and/or published past the expiration date and there is no obligation to remove any Multimedia that have already been posted or published.

I understand that I will be given a copy of this signed consent and authorization.

\_\_\_\_\_  
Signature of Resident/Client

\_\_\_\_\_  
Signature of Resident/Client Representative (if applicable)

Date: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Kaua’i Adult Day Health Center Staff Representative

Description of Representative’s authority:  
\_\_\_\_\_

K A U A I  
**Adult Day Health**



**Fee Schedule**

Effective: **March 1, 2026**

	<b>DAY CARE</b>
Monthly Rates	(based on \$85/day)
5 days/week	\$1,700
4 days/week	1,360
3 days/week	1,020
2 days/week	680
Daily Drop-In Rates:	\$100/day
Drop ins will be based on availability. Family/caregivers may call 24 hours in advance for availability. Payment will be due each day.	

Late Pick-Up Fees:	Any pick up after 5:30PM \$25/15 minutes
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K A U A I

# Adult Day Health



## 2026 Holiday Schedule

Kauai Adult Day Health Center will be closed on the following days:

<b><u>Holiday</u></b>	<b><u>Date Observed</u></b>
New Year's Day	Thursday, January 1
President's Day	Monday, February 16
Good Friday	Friday, April 3
Memorial Day	Monday, May 25
Kamehameha Day	Thursday, June 11
Independence Day	Friday, July 3
Admissions Day	Friday, August 21
Labor Day	Monday, September 7
Thanksgiving Day	Thursday, November 26
Christmas Day	Friday, December 25

# ABOUT OPH

## OHANA PACIFIC FAMILY

Ohana Pacific is the largest post-acute care organization in the state, providing quality experiences to Hawai'i's kūpuna that places health and well-being at the forefront of the care management model. Founded on O'ahu in 1998, the company now includes over 17 health care entities that employ approximately 1,500 team members who serve the community with quality, continuous care including long-term care, rehabilitation services, memory care, home health services and adult day health programs.

Day in and day out, our mission is to care for kūpuna.

We are one ohana, united by our core values. We are mission driven - our core values guide our communities and how we care for kūpuna.

[www.ohanapacific.com](http://www.ohanapacific.com)



# K A U A ' I Adult Day Health



*caring for kūpuna*



## GET IN TOUCH

2943 Kress Street  
Līhu'e, HI 96766

(808) 246-6919  
[kadh@ohanapacific.com](mailto:kadh@ohanapacific.com)



[ohanapacific.com/kadh](http://ohanapacific.com/kadh)

@kadhbyoph



## ABOUT KAUA'I ADULT DAY HEALTH

Kauai Adult Day Health provides quality and engaging daytime experiences for adults and seniors within a safe and supportive environment. Located in the heart of Lihu'e, we offer a variety of social and recreational activities to support physical and cognitive health and enhance quality of life. We serve as a place of connection and community for participants and a source of respite for caregivers.

*"The greatest and long-lasting blessing was that both of my parents began attending the Kauai Adult Day Health program. On the first day, I told my parents that I would pick them up in the early afternoon. When I went there, the group was singing karaoke and my dad was actually excited. They told me that they didn't want to leave yet and to come back later. That is when I knew this program was so special."*

- Wade Tanaka, son of client at Kauai Adult Day Health



## SERVICES

- Individualized Care Plans
- Health monitoring
- Assistance with eating, toileting, and walking
- Medication reminders
- Personal Care
- Nursing Care
- Referrals and Resource Information

## ACTIVITIES

- Exercise programs
- Educational and Social Activities, Games
- Special Event, Holiday, and Birthday Celebrations
- Arts & Crafts
- Music Activities
- Relaxation techniques

## ELIGIBILITY

**Adult Day Health** applicants have a need for daytime assistance and supervision. Clients may require standby assistance when walking, assistance with tendencies to wander, one-to-one assistance with transfers and toileting, assistance with eating or mechanically altered diets, nursing assistance, and medication reminders.

*Kauai Adult Day Health is a Kūpuna Cares service and is funded partially with state funds. This institution is an equal opportunity provider.*



County of Kauai  
Agency on Elderly Affairs  
AGING AND DISABILITY RESOURCE CENTER