KAUA'I
Adult Day Health

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: _____

Seconday 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 #: _____

KAUA'I
Adult Day Health
by aph

Admission Packet Items

- Application for Admission
- Required Admission Documents
- Admission Agreement
- Medical History Form
- Hawaii Advance Health Care Directive
- Hawaii POLST Form
- Respiratory Policy
- Client Rights
- Caregiver Pledge
- Admission Checklist
- CACFP Meal Benefit Form
- CACFP Enrollment Statement
- Transportation Waiver
- Fee Schedule
- Holiday Schedule
- Program Brochure

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Adult Day Health
by aph

Documentation Required Prior to Admission

- ❑ Admission Application
- ❑ Physical Exam Form
- ❑ Hawaii Advance Health Care Directive
- ❑ CACFP Enrollment Statement
- ❑ CACFP Meal Benefit Form
- ❑ Hawaii POLST Form
- ❑ COVID-19 Policy
- ❑ Transportation Waiver
- ❑ Admission Checklist
- ❑ Admission Agreement
- ❑ 2 Step TB Test

KAUA'I
Adult Day Health
by oph

Admission Agreement

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
2. President's Day
3. Good Friday
4. Memorial Day
5. King Kamehameha Day
6. Independence Day
7. Admission Day
8. Labor Day
9. Thanksgiving 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 20th 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.

Additional Services (at an added cost)

1. Shower service: $40 per shower upon availability. Because this is often a non-covered benefit by the payors, participants are financially responsible and will be billed the following month.
2. Therapy including physical therapy, occupational therapy, and/or speech therapy. For more information contact our Day Health Specialist at (808) 246-6491.

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 moth 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

PERSONAL INFORMATION:			
Name:	Address:		
Marital Status:	Birthdate:	Age:	Sex:
Physician:	Telephone:		
Medical Diagnosis:			

RN may administer medications at the Day Health Center

Present Medications: (Name of Drug, Dosage, Time)

1	5
2	6
3	7
4	8

(*Clients are at the Center from 7:30a.m. to 5:30p.m. weekdays)

PERTINENT MEDICAL HISTORY:

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 (Attach copy of Adv. Directive/ POLST)

Rehab Potential: Good_____ Fair_____ Poor_____

PHYSICAL EXAMINATION:

General: 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:			
Date of last Influenza Vaccination Received:			
Diet: 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

KAUA'I
Adult Day Health
by aph

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,

Alyssa Kuieck, BSN, RN
Program Coordinator/Registered Nurse

HAWAIʻI 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

YOUR NAME: (Please sign in front of witnesses or notary public)

_____

Print Your Full Name Your Signature Date of Birth Date

WITNESSES: CHOOSE EITHER OPTION 1 OR 2, NOT BOTH.

Important: Witnesses cannot be your health care agent, a health care provider or an employee of a health care facility. One witness cannot be a relative or have inheritance rights.

OPTION 1: WITNESSES

I (Witness 1) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not related by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of her/his estate. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

_____

Witness #1 Print Name Witness Signature Date

_____

Street Address City State Zip

I (Witness 2) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

_____

Witness #2 Print Name Witness Signature Date

_____

Street Address City State Zip

OPTION 2: NOTARY PUBLIC

State Hawai'i,
(City and) County of _____ } ss.

On this _____ day of _____, in the year _____, before me, _____, (insert name of notary public) appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this ___ -page Hawai'i Advance Health Care Directive dated on _____, in the _____Judicial Circuit of the State of Hawai'i, and acknowledged that he/she executed the same as his/her free act and deed.

_____

Signature of Notary Public

My Commission Expires:_____

A copy has the same effect as the original.
www.kokuamau.org/resources/advance-directives
Developed by the Executive Office on Aging and
Kōkua Mau - Hawai'i Hospice and Palliative Care Organization

Place Notary Seal or Stamp Above

December 2015

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

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAIʻI

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** (**A**llow **N**atural **D**eath)

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

☐ Long-term artificial nutrition by tube

☐ Defined trial period of 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:

☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate

☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ 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)

Signature of Provider (Physician/APRN/PA licensed in the state of Hawaiʻi.) 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

Patient's Preferred Emergency Contact (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

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** 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 • kokuamau.org

KAUA'I
Adult Day Health
by oph

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:

_____
Name of Participant

_____
Signature of Participant or Responsible Party

_____
Date

KAUA'I
Adult Day Health
by aph

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 charged, 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 ant 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 entitles 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. By 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.

KAUA'I
Adult Day Health
by aph

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 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 woodworking 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.

KAUA'I
Adult Day Health

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 "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 on 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 10th 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	

KAUA'I
Adult Day Health
adh

Dear Participant or Parent/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: Kauai Adult Day Health Center, 2643 Kress Street, Lihue, Hawaii 96766.**

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 U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

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 Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, 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
Washington, D.C. 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

If you have other questions or need help, call **(808) 246-6919.**

Sincerely,
Kauai Adult Day Health Center

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 this question if you choose to.

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.
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: Answer this question if you choose to.

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.

Part 1. Participant enrolled to receive day care.

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

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

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

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:	Mark one or more racial identities:	
❑ Hispanic or Latino	❑ Asian	❑ American Indian or Alaska Native
❑ Not Hispanic or Latino	❑ White	❑ Native Hawaiian or Other Pacific Islander
	❑ Black or African American	

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: _____

INSTRUCTIONS FOR COMPLETING
BENEFIT INCOME ELIGIBILITY ADULT DAY CARE CENTERS

Income Guidelines for Reduced Priced Meals
Effective July 1, 2023 to June 30, 2024

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	$31,025
2	$41,958
3	$52,892
4	$63,825
5	$74,759
6	$85,692
7	$96,626
8	$101,559
Each additional person:	+$10,934

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application.

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.

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

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.
Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf,from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
   U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D.C. 20250-9410; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider

Enrollment Statement
Child and Adult Care Food Program

_____
Participant's Name
is enrolled at:

Name of Center:_____
Address:_____
Beginning on:_____
Month/Day/Year

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

Signature_____ Date_____
Participant/Guardian
Signature_____ Date_____
Center Administrator

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To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

1. **mail:**
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2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   program.intake@usda.gov

This institution is an equal opportunity provider.

For Center use only

Participant withdrawn on _____

revised June 2023

KAUA'I
Adult Day Health
ODH

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.

2943 Kress Street Lihue, Hawaii 96766 Telephone: (808) 246-6919 Fax: (808) 246-6911

KAUA'I

Adult Day Health

by aph

Fee Schedule

Effective: **January 1, 2023**

	DAY CARE
Monthly Rates	(based on $79/day)
5 days/week	$1,580
4 days/week	1,260
3 days/week	950
2 days/week	630
Daily Drop-In Rates:	$94/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

KAUA'I
Adult Day Health
by aph

2024 Holiday Schedule

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

Holiday	Date Observed
New Year's Day	Monday, January 1
President's Day	Monday, February 19
Good Friday	Friday, March 29
Memorial Day	Monday, May 27
Kamehameha Day	Tuesday, June 11
Independence Day	Thursday, July 4
Admissions Day	Friday, August 16
Labor Day	]Monday, September 2
Thanksgiving Day	Thursday, November 28
Christmas Day	Wednesday, December 25

ABOUT OPH

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 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

OHANA PACIFIC HEALTH

OHANA PACIFIC FAMILY

- Ann Pearl REHAB & NURSING
- Legacy Hilo REHAB & NURSING
- Garden Isle REHAB & NURSING
- Pu'uwai 'O Makaha REHAB & NURSING
- Hale Kūpuna HERITAGE HOME REHAB & NURSING
- THE VILLAS POST ACUTE CARE REHAB
- Hale Makua REHAB & NURSING
- Home Health
- Hale O Meleana RESIDENTIAL & MEMORY CARE COMMUNITY
- Adult Day Health

GET IN TOUCH

Address: 2943 Kress Street,
Līhu'e, HI 96766
Phone: (808) 246-6919
Website: ohanapacific.com

04.23

CARING FOR KŪPUNA

KAUA'I

Adult Day Health

ABOUT KAUA‘I ADULT DAY HEALTH

Kaua'i Adult Day Health provides a quality and engaging day time program experience for adults and seniors. Located in the heart of Līhu‘e, we offer a variety of social interactions and recreational activities within a group setting that support participants’ physical and cognitive functioning; thereby enhancing quality of life and providing caregivers with much needed respite. Participants develop relationships and experience a sense of belonging within a safe and supportive environment.

“In this season of my mother's life, Kaua'i Adult Day Health Center has been the greatest opportunity for her to socialize, be active, meet new people, and keep her mind busy. The biggest assurance is knowing that my mom is well cared for by the staff while I am at work. The best thing for our family, is listening to all the stories my mom shares about her joyous time spent there."

- Dayna Santos, caregiver of client at Kaua‘i Adult Day Health

SERVICES

- Individualized Care Plans
- Health monitoring
- Assistance with eating, toileting, and walking
- Assistance with medication
- 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 therapy
- Relaxation techniques
- Excursions

ELIGIBILITY

Day Health Applicants may require assistance with frequent incontinence, a mechanically altered diet, standby assistance when walking, assistance with tendencies to wander, one-to-one assistance with transfers, assistance with eating, specialized nursing assistance, assistance and/or administration of medication.