



Lunalilo Home
Adult Day Care

501 Kekāuluohi Street
Honolulu, Hawaii 96825
(808) 395-4065

Dear Family and Friends,

Thank you for your recent inquiry about our Adult Day Care Program, we hope you find the information provided to be helpful.

We are looking forward to your participation and would like to welcome you and your family to come and visit our center in order for you to make the right decision for you and your loved one.

The documents are separated into three sections:

A. For you to keep.

- a. Philosophy
- b. General Requirements and Eligibility
- c. Summary Schedule of Rates & Fees
- d. Participant's Rights

B. For you to complete and return to Lunalilo Home Adult Day Care.

- a. Application
- b. Participation Agreement
- c. Authorization for Disclosure of Health Information (HIPPA)
- d. Photography Waiver
- e. "Getting to Know You"
- f. Submit \$50 Registration Fee

C. For your Doctor to complete and for you to return to Lunalilo Home Adult Day Care.

- a. Physical Examination Form
- b. Physician's Examination and Orders (only if medications will be dispensed at ADC by licensed staff) Form to be requested.
- c. Diet Order Request
- d. Physician Orders for Life-Sustaining Treatment (POLST)
- e. Two Step TB Clearance

After we have received all the appropriate documents from section B and C, we will start the admission process to Lunalilo Home Adult Day Care. If you have any questions please feel free to contact me at 395-4065.

Sincerely,

Iwalani Ah Quin
Program Director of Adult Day Care & Senior Activities



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Day Care Philosophy, General Requirements and Eligibility, Services Provided, Rates and Charges

Philosophy

Lunalilo Home Adult Day Care provides quality adult day care services in a nurturing, safe and secure environment to adult individuals whom we are able to accommodate under an Adult Day Care Program in consonance with the State of Hawaii's Administrative Rules for Adult Day Care Centers. The philosophy and objectives of the day care program are:

1. In the spirit of a long standing tradition of Lunalilo Home; we seek to promote the physical, spiritual, mental and emotional well-being of day care participants in a meaningful environment of cheer and contentment, Hawaiian culture, aloha and `ohana.
2. To enable the day care participant to develop relationships outside the family in a socially stimulating setting; to reintroduce participants or allow them time to adjust to group interaction; to reduce or prevent physical and emotional withdrawal or isolation that can result when elders live alone or are left alone for long periods to time.
3. To maximize the participant's functioning and well-being; to lessen, delay and prevent functional regression.
4. To provide family caregiver(s) with time and opportunities to care for their own needs or pursue their own interests by providing care and supervision outside of the caregiver's home.
5. To provide relief from the demands of constant caregiving; to refresh and rejuvenate the caregiver; enabling continuation of in-home care and to prevent or reduce the incidence of elder abuse that results from caregiver's "burnout" or stress.
6. To provide time to review and evaluate other care alternatives for the elder, including the possibility of long-term care placement; to delay institutionalization or long-term care placement for as long as possible.
7. To offer high quality professional care services in a secure, safe and meaningful environment to caregiving families and day care participants.

All participants of the center's day care program shall be accorded the same consideration, respect and understanding; and granted the same rights to which all Lunalilo Home Adult Day Care participants are entitled.



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General Requirements and Eligibility

The center's day care program is open to elders and their care giving families who are in need of healthcare services and would benefit from such a program. Day care participants must submit a completed history and physical examination report and TB clearance prior to admission. The confidentiality of participant information will be respected and released only by permission and in accordance with regulations.

Primary caregivers (family members, friends, etc.) and prospective participants are urged to visit and get a feel for the center by speaking with the day care Program Director or staff prior to submitting an application. Applications for admission to the day care program, to be considered, must be accompanied by a non-refundable \$50 registration fee upon submission of application.

Lunalilo Home Adult Day Care is unable to serve or accept into the program persons who are severely disabled or bed bound, those with infectious diseases, or sub-acute illness, those with unmanageable psychiatric or behavioral conditions or disorders, or those with special monitoring equipment that require the constant attention of a licensed professional nurse.

All day care program services will commence after application and registration are processed. Thereafter, schedules of service may be arranged according to the convenience of the participant and/or caregiver. Changes in schedules must be made 2 weeks in advance. The center cannot accept any non-registered "drop-in" participant.

During days of program participation, participants must be free of gastro-intestinal (diarrhea) and respiratory infection (influenza and common cold). For the consideration of other participants please do not send a sick client to the program. If a client is ill or becomes ill while at the center the responsible party will be notified and expected to pick up the client as soon as possible to prevent the spreading of illnesses. Families are asked to keep their family member home until they have been free of fever and symptoms for 24 hours.

For all medications, a completed Physician's Order Form is to be completed before any medication can be administered by Lunalilo Home's licensed staff. Medications to be given to the participant during the day must be left in their original container bearing the prescription label which shows the date filled the physician's order's and correct amount to be taken. You may request your Pharmacist to prepare two (2) containers one for the medication to be brought to the center and another to keep at home. The empty container will be returned home with the participant at the end of the day. Participants that require medication to be administered by the licensed staff will be assessed a daily fee of \$30.00.

Since care of the older adult of extreme age and frailty or irreversible cognitive impairment can be very demanding, the day care Program Director, Program Coordinator and staff invite and expect the collaboration and support of family caregivers, so the best interests of the participant are served. We find that attending our program a minimum of twice a week, allows the participant to get acclimated to our program in a timely manner and helps them to develop a social connection with other participants and staff.



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Hours of Operation

1. Day care services are offered Monday through Friday 6:30 a.m. – 6:00 p.m. except on recognized holidays. Effective April 1, 2017, our day care center's hours of operation will be 6:30am – 5:30pm except on recognized holidays.

2. Lunalilo Home Adult Day Care recognizes the following holidays and will be closed.

- **New Year's Day**
- ****Presidents' Day**
- ****Kuhio Day**
- ****Good Friday**
- ****Memorial Day**
- ****King Kamehameha Day**
- **Independence Day**
- **Labor Day**
- ****Veterans' Day**
- **Thanksgiving Day**
- **Christmas Day**

NOTE: Holidays with “**” ADC will operate if 12 clients sign-up. No refunds on cancellations.
Hours of Operation: 8:00am – 4:30pm, Lunch Only.

Basic Services Provided

1. Management and conduct of our day care program by professional and trained providers including initial and periodic assessment, evaluation, and/or consultation with Program Director and/or licensed personnel.
2. Day care plans of care, activities, excursions and schedules developed and tailored to meet individual needs and diagnoses.
3. Supervision with standby to moderate assistance as needed for selected activities of daily living such as transferring, toileting and eating. Training or reminding provided as indicated.
4. Lunch is served daily. Snacks are served mid-morning and mid-afternoon. To-Go dinners are available for a nominal charge.
5. Health status observation and condition monitoring as needed; first aid treatment and/or cardio-pulmonary resuscitation in the event of medical emergency.
6. Access and use of the center's building, grounds, equipment and supplies by day care program participants as called for.

Enhanced Services – NOT included in basic day care rate:

1. Extra Supervision.
2. Transfer Assistance.
3. Incontinence Care.
4. To-Go Dinners.
5. Dispensing of prescribed medication.



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Application and Admission Procedures

Persons interested in the center's day care program should inquire at Lunalilo Home Adult Day Care, 501 Kekāuluohi Street, Honolulu, Hawaii 96825 Telephone (808) 395-4065, Attention: Program Director. The applicant and/or family shall be fully informed as to the various day care program contents, objectives, expectations, limitations and costs. They shall be given opportunity to inspect the facility and make inquiries. **The completion and/or submission of the following information and forms initiate the application process leading to admission into the day care program:**

- 1. Application form**
- 2. "Getting To Know You" form**
- 3. Authorization for Health Information**
- 4. Physical examination report, TB clearance**
- 5. Diet Order**
- 6. Non-refundable \$50 registration fee with application**

Following the completion and submission of the above, notification will be made and an appointment for an interview and further evaluation will be scheduled to include the day care Program Director the applicant and family members or caregivers.

An applicant shall be accepted or admitted into the day care program if suitable as determined by the Program Director and if the applicant and/or family representative contracts for and schedules service(s) and agrees to the conditions set forth by signature.

The day care Program Director will schedule days of service as desired of the participant and/or family representative.

Payment Policy and Fees

In order to reserve a space in the ADC program, clients are responsible for full payment of monthly fees in advance of services rendered. Monthly statements are sent the last week of the month proceeding the month of services rendered. Payment may be made directly to the Adult Day Care (ADC) Office or by mail by the 5th working day of each month.

Participants will be charged for their regular schedule (eight day minimum for the month), whether utilized or not. Clients or caregivers are asked to provide written notification to the Program Director when they wish to terminate services.

The center is open from 6:30 AM until 5:30 PM Monday through Friday and on Saturday from 8:00 AM until 4:30 PM. Clients are to be dropped off after 6:30 AM and picked up before 5:30 PM Monday through Friday. On Saturday, clients are to be dropped off after 8:00 AM and picked up before 4:30 PM. A client that is dropped off before or after hours of operation will be charged early drop off/late pick up fees of \$25.00 per quarter hour.

Basic rates are inclusive of the costs of supplies with the exception of disposable briefs, medications, ambulance service or services rendered by another agency, facility or third party provider. The excluded costs shall be the responsibility of the participant or his/her family.



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SUMMARY SCHEDULE OF RATES & FEES

Registration Fee – Day Care Program, non-refundable (Given with completed application forms)	\$50
Basic Day Care rate per day session (Minimum 8 sessions/month)	\$78
Enhanced services, not included in Basic Day Care rate and charged each day of delivery unless otherwise indicated:	
1. Behavior and acuity management, Incontinence Care, Extra Supervision, Transfer Assistance, etc.	\$30
2. Dispensing of prescribed medication by LPN or RN.	\$30
3. To go dinner.	\$7.20
4. Late or no cancellation fee.	\$7.25
5. Early/Late pick up fee. (every additional 15 minutes fee added)	\$25.00

NOTE: All rates and fees are subject to change or may be added without notice



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Participant's Rights

As a participant of Lunalilo Home Adult Day Care, you have the right to:

1. Be fully informed, orally or in writing, prior to or at the time of admission, of your rights and all rules governing participant conduct. There shall be documentation signed by the participant's legal guardian or both, that these rights have been received and acknowledged.
2. Be fully informed, prior to or at the time of admission, of services available in or through the center, including any charges not covered by the program's basic daily rate.
3. Be given reasonable advance notice of discharge for medical reasons, for your welfare or for the welfare of other participants in the program or for non-payment for your stay. Such action will be documented in the participant's record.
4. Be encouraged and assisted to exercise your rights as a participant including, but not limited to, the right to voice grievances and recommend changes in policies and services to the staff or outside representatives of your choice; the right to be free from interference, coercion, discrimination, or reprisal. You may express dissatisfaction with staff performance or services and seek resolution through a complaint or grievance procedure, which will be provided to you.
5. Be free from humiliation, harassment, threats, and chemical or physical restraints.
6. Expect that your personal and medical records are confidential. You may approve or refuse release of any information to anyone outside of the center. However, if the Program Director or Program Coordinator determines that a refusal to release pertinent information to an appropriate party is detrimental to the program, admission can be denied.
7. Be treated with understanding, respect, and full consideration of your dignity and individuality, including privacy in treatment and in care of your personal needs.
8. Not be required to perform services for the center except for therapeutic purposes included in your plan of care.

As a participant of the Lunalilo Home Adult Day Care Program, you have the responsibility to:

1. Cooperate with program staff regarding the provision of treatment, therapeutic activities and daily exercise.
2. Respect the rights of staff and other clients and to treat them with respect.



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APPLICATION FOR DAY CARE SERVICES

Name Last First MI Date of Application

Address City State Zip Phone

SSN Marital Status S M W D Birthdate Birthplace

Birth Country Entry to USA U.S. CITIZEN? YES

NO

Ethnicity Languages Spoken

Referred By / From Religious Affiliation / Church or Temple

Military Service History of Falling History of Wandering Has Healthcare Power of Attorney

Has Durable Power of Attorney Has Advanced Directives/Living Will Has POLST

Days Service Requested: MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY

Client Current Mailing Address Number/Street City State Zip

PROVIDERS:

Primary Care Physician Address

Phone: Fax: Pager:

Preferred Hospital Preferred Mortuary

Health Insurance Carrier: Policy#:

MediCAID No. MediCARE No. Drug Plan

Responsible Party(s) in order of priority:

1) Name Relationship

Address City State Zip Code

Home Phone: Cell Phone: Work Phone:

Email

Emergency Contact Holds Healthcare Power of Attorney Holds Durable Power of Attorney

Responsible for Payment

2) Name Relationship

Address City State Zip Code

Home Phone: Cell Phone: Work Phone:

Email

Emergency Contact Holds Healthcare Power of Attorney Holds Durable Power of Attorney

Responsible for Payment

3) Name Relationship

Address City State Zip Code

Home Phone: Cell Phone: Work Phone:

Email

Emergency Contact Holds Healthcare Power of Attorney Holds Durable Power of Attorney

Responsible for Payment

Food/Drug Allergies:

Primary Diagnosis/Chronic Condition:

Person Completing Application: Relationship Date



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PARTICIPATION AGREEMENT

I, or my representative, have read Lunalilo Home Adult Day Care Program’s Philosophy, General Requirements and Eligibility, Services Provided, Rates and Charges, Participant Rights and Rules and Regulations.

I, or my representative, agree to pay Lunalilo Home, upon receipt of notice. Payments are non-refundable with exception of loss of life or emergency closure of the center.

Each client’s physician will be requested to complete an annual medical evaluation (form provided by Lunalilo Home Adult Day Care) and a negative TB skin test.

If a health emergency arises while at Lunalilo Home Adult Day Care, the family will be notified. If necessary, the client will be transported to the hospital by the family, or by an ambulance obtained by Lunalilo Home Adult Day Care at the family’s expense. I also authorize Lunalilo Home Adult Day Care to contact another physician when a regular physician cannot be contacted.

All medications shall be in a pharmacy-labeled bottle and kept in a locked box at Lunalilo Home Adult Day Care. The client’s physician must sign an authorized statement for licensed staff of Lunalilo Home to administer medication.

I give my permission for visual or auditory recordings of me, alone or with others, to be made or taken for non-commercial purposes.

I, or my representative, understand that Lunalilo Home Adult Day Care shall not be held responsible or liable for actions or outcomes over which it has no control, not done with harmful or malicious intent or not due to negligence.

I, or my representative, understand that Lunalilo Home Adult Day Care is not responsible for any valuables or money kept in client’s possession.

_____ Date _____
Print Client’s Name: Client’s Signature:

_____ Date _____
Or Representative’s Name: Representative’s Signature:



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I, _____, authorize Lunalilo Home Adult Day Care and Lunalilo Home to disclose health information relating to my health, disability or illness condition to the following individual or entity:

(Please initial for authorization)

_____ Lunalilo Home Adult Day Care and Lunalilo Home.

_____ My physician or other provider giving medical services in an emergency situation involving me.

_____ Other _____

For the following purposes:

- To provide the medical resources I may require and/or in a medical emergency situation.
- To be used as required or permitted by various state and federal laws;
- Other entities may use your health information for purposes of payment; conducting quality assurance activities or outcomes assessments; reviewing the competence or qualifications of health care professionals; performing accreditation, licensing, or credentialing activities; analyzing health plan claims or health care records data; evaluating provider clinical performance; carrying out utilization management; or conducting or arranging for auditing services in accordance with statute, rule or accreditation requirements.

This consent to disclose health information begins effective immediately. I understand that I can revoke this authorization in writing at any time, but it is valid until revocation in writing.

Signed _____ Date _____

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

I, _____, authorize my physician or other provider giving me medical services relating to my health, to disclose health information relating to my health, disability or illness condition to Lunalilo Home Adult Day Care and Lunalilo Home the following purposes:

- To provide the medical resources I may require and/or in a medical emergency situation.
- To obtain information about my health and medical history for possible participation in the Adult Day Care Program at Lunalilo Home.
- To be used as required or permitted by various state and federal laws;
- Other entities may use your health information for purposes of payment; conducting quality assurance activities or outcomes assessments; reviewing the competence or qualifications of health care professionals; performing accreditation, licensing, or credentialing activities; analyzing health plan claims or health care records data; evaluating provider clinical performance; carrying out utilization management; or conducting or arranging for auditing services in accordance with statute, rule or accreditation requirements.

This consent to disclose health information begins effective immediately. I understand that I can revoke this authorization in writing at any time, but it is valid until revocation in writing.

Signed _____ Date _____



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PHOTOGRAPHY AND PUBLICATIONS GENERAL WAIVER AND RELEASE

Blanket Approval for All Events

In consideration of our mutual promises and other valuable consideration, I hereby authorize you and your agents, whomsoever to make, distribute, exhibit, reproduce, sell or assign and otherwise use my name and photographic likeness and own the negative of the pictures you have taken of me and in the use of photographic likeness and the use of my name. You may and can use said name and likeness in regard to any subject matter whatsoever you choose whether it be in regard to a picture or series of pictures to be produced, taken, exhibited, or used or part of it used in any format, campaign, news release, media of any type or kind whether or not produced by you or used by a principal and/or agent and/or employee of yours, so long as the aforesaid is released according to your direction.

I hereby waive all rights or claims in regard to invasion of the right of privacy, invasion of the right of publicity, any type of defamation, and I hereby waive all rights of inspection of approval and irrevocably release you and all of the parties whomsoever you may choose to use my likeness, name, or photograph from any liability arising out of or in connection with the use of my name, photographic likeness, negatives or ownership in and to my photograph and other subject matter as set forth including but not limited to those causes of action named herein and any other cause of action that may accrue to me by the use thereof. However, I understand that this Waiver and Release releases and forever holds you harmless from any and all liability in the use whatsoever of the hereinabove enumerated photographic likeness of me.

In addition, I hereby extend the same authorization and waiver of rights or claims as stated above to Lunalilo Home in regards to personal interviews, articles and write-ups based on such interviews that are submitted to and published for Lunalilo Home Newsletters or other newspapers and publications. The articles will be subject to final editing and publication by the publisher.

This agreement is intended to bind my heirs, assigns, agents, subsidiary companies and other individuals whosoever I am connected with, either legally or by contract.

Name(s): _____

Status/Relationship to Lunalilo Home (client, resident, volunteer, visitor, staff, etc.): _____

Print Name of Authorizing Agent: _____ Relationship _____

Signature: _____ Date: _____

Parent/Guardian Signature (if the above is under 18 years old): _____



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“GETTING TO KNOW YOU”

APPLICANT: _____ AGE: _____ SEX: _____

To find out if you or the applicant would benefit from the type of services our day care offers, please mark “X” in the appropriate column. **There are no right or wrong answers.**

DESCRIPTIVE STATEMENT	YES	NO
Is alert and aware of his/her surroundings.		
Gets lost or wanders away more than once a week.		
Should not be left alone at all.		
Walks slowly, but without help of any kind.		
Uses cane or walker to walk around.		
Must be fed by another person.		
Able to feed self or uses assistive eating ware.		
Needs help of another person to get out of bed.		
Does not walk, usually stays in bed or room.		
Able to go to bathroom by self.		
Has frequent bladder/bowel accidents, uses protective undergarments.		
Can take care of toilet needs when reminded.		
Has a skin sore or ulceration.		
Under doctor’s care for medical condition.		
Is taking medicine/medication by injection.		
Is hard of hearing, has poor eyesight or both.		
Is sometimes forgetful but less than twice a week.		
Unable to remember beyond five (5) minutes.		



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PARTICIPANT PHYSICAL EXAMINATION FORM (CONFIDENTIAL)

Name _____ Birth Date _____ Sex M F

MEDICAL FINDINGS (To be completed by Physician or Records Librarian)

Weight _____ Height _____ Ears/ Hearing: Rt. ____/20 Lt. ____/20

Eyes _____
Vision without glasses Rt. 20/ _____ Lt. 20/ _____ with glasses Rt. 20/ _____ Lt. 20/ _____

Mouth, throat and nose: _____

Lungs _____ Dyspnea _____ Cyanosis _____

Heart and circulatory system: _____

Blood Pressure _____ Pulse Rate _____

Abdomen _____

Genito-urinary and gynecological _____

Continence status _____ Type _____

Rectal/(Hemorrhoids, etc.) _____

Extremities _____ Edema _____

Nervous system _____

Psychiatric and/or Psychological Findings _____

Other Conditions _____

Substantiating Laboratory Findings _____

DIAGNOSIS: Primary _____

Secondary _____

Present Medical Treatment _____

Current Medications _____

Activities to be avoided _____

Appropriate for Adult Day Services YES NO

2 Step TB Clearances: Step One Dates: _____

Step Two Dates: _____

Vaccines Date

Pneumovax _____

Influenza _____

Tetanus _____

Examiner's Name _____

Date of Examination _____

Examiner's Signature _____

Signature Date _____



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NAME OF PARTICIPANT _____

DATE	PHYSICIAN'S EXAMINATION AND ORDERS (For Medication Administration at ADC by Licensed Staff)	SIGNATURE & CLINIC

PHYSICIAN'S RECORD



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PHYSICIAN'S DIET ORDER

Date: _____

Client's Name: _____ Date of Birth: _____

Physician: _____

Previous Diet Order: _____

Please check appropriate diet order you would like your patient to have at King Lunalilo Adult Day Care.

Your new prescribed diet order:

- _____ Regular, Regular Consistency or Texture
- _____ Regular Mechanical Soft Diet ___ Cube ___ Chop ___ Minced
- _____ Regular, pureed consistency
- _____ No concentrated sweets (NCS) ___ Reg ___ Cube ___ Chop ___ Minced
- _____ No concentrated sweets (NCS), pureed consistency

Sodium Controlled Diets:

- _____ 3 gm Na or No Added salt (NAS) ___ Reg ___ Cube ___ Chop ___ Minced
- _____ 3 gm Na or No added salt (NAS), pureed consistency
- _____ 2 gm Na ___ Reg ___ Cube ___ Chopped ___ Minced
- _____ 2 gm Na, Pureed consistency
- _____ DASH (Dietary Approaches to Stop Hypertension)

Dysphagia Diets:

- _____ Dysphagia Stage 1 or Dysphagia Pureed Diet
- _____ Dysphagia Stage 2 or Dysphagia Minced Diet
- _____ Dysphagia Stage 3 or Dysphagia Chopped Diet
- _____ Dysphagia Stage 4 or Dysphagia Soft Diet

Dysphagia Liquids:

- _____ Thin or No Restriction _____ Honey _____ Nectar _____ Pudding

Please list known food allergies: _____

Diet-Drug Interactions: _____

Physician's Signature: _____ Date: _____