WAIANAE COAST COMPREHENSIVE HEALTH CENTER
www.wcchc.com

# ADULT DAY CENTER APPLICATION

**Mililani Hale**
**95-257 Kaloapau Street**
**Mililani, HI 96789**

## QUESTIONS? Call Director Lemetrica White, RN, at (808) 561-2147

The Adult Day Center provides a program for frail adults in need of supervision, protection and socialization. Activities include arts and crafts, entertainment, field trips, music and dance, exercises, games, small group activities and opportunities for socialization with peers and staff. Services include assistance with toileting and meals. Tuition includes breakfast, hot lunch and a nutritious snack.

**APPLICATION FOR ENROLLMENT**

Name: _____ DOB: _____ Age: ___ Gender: M/F SSN#: _____

Address: _____ City: _____ Zip Code: _____

Phone #: _____ Alt. Phone #: _____

Marital Status: _____ Yrs. Of Education: _____ Former Occupation: _____

Living Arrangements: _____ Code Status _____

**PRIMARY CAREGIVER**

Name: _____ Relationship: _____

Address: _____ Phone: _____ Alt. Phone: _____

**EMERGENCY CONTACT**

1. Name: _____ Relationship: _____

Address: _____ Phone: _____ Alt. Phone: _____

2. Name: _____ Relationship: _____

Address: _____ Phone: _____ Alt. Phone: _____

**THIS SECTION TO BE COMPLETED BY ADULT DAY CARE STAFF**

**Interview Date:** _____

**Assessment Date:** _____ **Signature:** _____

**Assessment By:** _____ **Signature:** _____

**Admission Date:** _____

**MEDICATIONS:**

WCCHC staff has my permission to provide reminders for medication that is taken while attending the center's Adult Day Care:

(Please initial)_____

**ACTIVITIES PERMISSION**

_____ Has my permission to participate in the Waianae Coast Comprehensive Health Center's (WCCHC) Adult Day Center activities that I have initialed below:

_____ Field trips in the WCCHC van
_____ Have pictures taken during special occasions, etc.

**GRIEVANCE PROCEDURE**

I understand that if I have a grievance about the services provided by the Center's Adult Day Care, I have an opportunity to voice my grievance. I can discuss the problem with the Adult Day Care Manager, Social Services Director, the Medical Director or the Executive Director. In addition, I can complete a "Patient Complaint Report" which will be provided, upon my request, by center staff.

(Please initial) _____

**EMERGENCY/MEDICAL PERMISSION**

I understand that in case on an emergency, WCCHC staff will initiate necessary emergency procedures and contact 911. If it is impossible to contact my family physician _____ at phone number _____, I further give my consent for staff to contact my alternate physician _____ at phone number _____.

(Please initial) _____

**FINANCIAL AGREEMENT** *** I understand that we will be charged for scheduled Days regardless of attendance. ***

I understand that tuition is $_____ per day

Tuition amount $_____ Paid by: _____

Early Drop Off $_____ Paid by: _____

We charge an additional $10 for early drop off between 7:00 am – 8:00 am

Initial:_____

**ATTENDANCE AGREEMENT**

Monthly Attendance Agreements must be submitted by the last business day of the previous month. Attendance is approved on a first-come, first-served basis so it it is advisable to submit Monthly Attendance Agreements as soon as possible prior to the deadline. All reservations approved in Monthly Attendance Agreements will be charged including any days not fulfilled.

Open 8:00 am – 5:00 pm, Monday – Friday
Closed weekends and observed holidays

Initial: _____

**RELEASE OF LIABILITY**

I hereby release the WCCHC and its staff, or other authorized agents acting for the said Center, from responsibility in case of accident or from any liability, which might be incurred while receiving services from the Center. I understand that Center activities, trips, and excursions will be adequately supervised and that every necessary precaution will be taken to insure the safety and the welfare of the participant. I understand that should an occasion occur involving wandering away from the center, after a reasonable search, that staff may contact the police for help in locating the participant.

(Please initial) _____

**SPECIAL INFORMATION**

Language Spoken: _____

Memory/Attention
- Short-term memory loss _____
- Short attention span _____
- Loss of vocabulary _____
- Limited comprehension _____
- Distractible _____

Behavior
- Wandering _____
- Anxiety _____
- Aggressiveness _____
- Suspicion/paranoia _____
- Other _____

Mobility
- Independent _____
- One-person assist _____
- Two-person assist _____
- Non-ambulatory _____

Mobility Aids
- Cane _____
- Walker _____
- Wheelchair _____

Assertive Devices
- Glasses _____
- Hearing Aide _____
- Dentures (upper) _____
- Dentures (lower) _____

Toileting needs
- Independent _____
- Needs reminders _____
- Needs assistance _____
- Incontinent
  - Bladder _____
  - Bowel _____
  - Diapered _____

Orientation
- Fully oriented _____
- Somewhat oriented _____
- Confused _____

Meals
- Independent _____
- Needs reminder _____
- Some assistance _____
- Total assistance _____
- Regular _____
- *Special Diet:
  - Puree _____
  - Chopped _____
  - Thick it _____

_____Initial

_____ _____ _____
Signature Relationship to client Date

_____ _____
Intake Staff signature Date

Director's Signature: _____