

590 Kapiolani Street
Hilo, Hawaii 96720

Welina mai! Welcome to Pohai Malama Care Home!

Mahalo for considering Pohai Malama Care Home as your choice for Adult Residential Care, where our friendly, experienced staff are dedicated to providing the highest quality of care for you or your loved one. We welcome you to become a part of our vibrant kūpuna community.

The enclosed information will be helpful in assisting in the decision-making process to determine if an Adult Residential Care Home is the best choice for you.

To begin the application process the following documents are required:

- Application to be completed by the potential resident and/or responsible party
- Medical forms to be completed by the applicant's Primary Care Provider (pages 13-19)

The completed documents are to be submitted along with a one-time, non-refundable application processing fee of $250 payable to Hawaii Care Choices. Minimum application processing time will be at least one (1) week.

Upon acceptance, and prior to moving in, the following document will be required as Pohai Malama Care Home follows the State of Hawaii's TB guidelines:

- Proof of **2-step Tuberculosis clearance** - If the applicant has a history of a positive test result, please submit proof of the positive test and a current chest x-ray result.

Should you desire to schedule a personal appointment to view our comfortable accommodations at Pohai Malama Care Home, or if you have questions we can help answer, please don't hesitate to contact us at (808) 934-2900.

Mahalo again for your interest in Pohai Malama Care Home! We look forward to hearing from you soon!



590 Kapiolani Street
Hilo, Hawaii 96720

ADMISSIONS CRITERIA

Pohai Malama Care Home (HOME) is a private, non-profit care facility for older adults. The HOME is licensed by the Hawai`i State Department of Health as an Adult Residential Care Home. The HOME provides 24-hour supervised care and supportive services in a cheerful ‘ohana (family) setting that promotes the physical, mental and emotional well-being of its residents.

A. REFERRAL

Any individual or organization may refer prospective residents to the HOME. Individuals, their providers, or any health care agency representative, social worker, or family member can request an application for long-term residency.

B. ELIGIBILITY

Upon initial admission, applicants must be an adult who is ambulatory or independently mobile with assistive devices (e.g. walker or single point cane) and in need of minimal to moderate supervision and/or assistance with personal care needs (activities of daily living - ADLs). The prospective resident must be able to adjust to congregate or group living.

1) All residents admitted to the HOME must have been examined by a licensed provider less than three (3) months prior to admission, and have documentation of a two-step TB clearance and a recent test within the previous year or a current chest x-ray result. Pohai Malama Care Home follows the State of Hawaii's TB guidelines. Before acceptance into the HOME, the prospective resident will be interviewed and evaluated as to suitability and appropriateness by the Administrator and/or Charge Nurse.

2) The HOME cannot accept anyone with acute psychiatric disorders or with severe behavioral problems. After admission, any resident who develops or manifests serious mental disturbance or behavior problems, or who develops a serious health or medical condition as determined by the HOME’s professional staff in conjunction with the resident’s attending physician, may be transferred to a more appropriate facility or released to his/her family or responsible party. Certain waivers may be considered as deemed appropriate by the Administrator and/or Charge Nurse.

3) No one will be admitted or maintained in the HOME when there is confirmation of communicable disease that cannot be adequately contained or controlled by the HOME.

C. SERVICES

The HOME provides 24-hour supervised care and supportive services to resident men and women residing in a congregate setting. Minimal or basic services include:

- Room and Board
- Bed and Bath Linens and Furnishings
- Laundry and Housekeeping Services
- Meal Planning, Preparation and Service
- Assistance with Personal Care - activities of daily living and instrumental or social functioning
- Health Status/Condition Change Monitoring
- Medication Management
- First Aid Care
- Implementation of Provider's Order or Treatment
- Professional Staff Consultation
- Recreational, Cultural and Spiritual Activities
- Miscellaneous Supplies/Services including:
- Hygiene and Grooming Aids - facial tissue, skin creams, lotions and lubricants, deodorants, oral and dental cleaners, hair care products, disposables (excluding incontinence products), etc.
- Snacks and treats.
- Activities/Programs - crafts and activity supplies and equipment, seasonal and holiday decorations, special events and outings that are sponsored by the HOME.

CI. RATES, FEES AND CHARGES

The HOME provides single occupancy rooms / accommodations with private ensuite bathrooms. In special situations room accommodations may be adjusted to two per room.

The monthly fee is based on accommodations and acuity level and/or Level of Care (LOC) required to provide quality care for each individual. The HOME will provide minimal assistance in the activities of daily living and personal care services for those residents who are considered Care Home LOC. When an applicant is assessed for admission, that individual's monthly fee will be discussed and determined with the family member(s) and/or responsible party. Please see the attached current fee schedule and explanation of acuity level for your reference. A security deposit equal to 50% of the monthly rent, plus the first month's rent are required to be paid in advance of moving into the care home. The security deposit will be refunded to the resident at such time the resident vacates the care home and no later than 14 days after vacancy. The security deposit will not be refunded if any of the following conditions apply: (1) Failure to pay rent due (2) To compensate for damages caused by the resident. (3) Failure to provide the proper notice of intent to vacate. On a limited basis, and depending on availability, short stay options may be made available. Short stay will be calculated by the week. A week is defined as seven (7) days. Minimum stay will be one (1) week, and maximum short stay will be no longer than 29 days. Days in between defined weeks will be charged at daily rate, not to exceed 29 days (see fee schedule). If stay is needed longer than 29 days, please refer to monthly fee, permanent status rates and rules. Use of semi-private rooms, if available, may be an option at a discounted rate. See administration for current rates.

Medicare, Medicaid and most health insurance providers do not cover the type of care services provided by ARCH's. Residents or their responsible party will be responsible for all rates and fees billed monthly by the HOME. Monthly invoices include pre-billing for the Monthly Service Fee (MSF) as well as any ancillary expenses incurred by the HOME on behalf of the resident. Payment will be made by direct deposit by the 1st of each month. Checks or credit card payments are also accepted but will be due by the 1st of each month. If paying by credit card, a service fee will be added based on the current credit card fee rate. The day for residents starts at 12 midnight. Any part of the day is considered a full day with regard to payment.

State regulations require that all residents who are hospitalized be considered "discharged" from the HOME. Should the resident be hospitalized, the Administrator will work with the resident or responsible party for re-assessment and bed holding options.

All residents or their legal guardian is responsible for the following:

- Mobility or assistive devices including specialized care equipment. (i.e. wheelchairs, walkers, commodes, specialty mattresses etc.)
- Professional or contracted servicing, repairing or cleaning of the above.
- Medications - prescription and non-prescription.
- Medical supplies, such as dressings, tape, gauze, ace bandages, etc.
- Incontinent supplies, non-emergency treatment supplies, oxygen supplies or concentrators, etc.
- Prescribed or referred therapeutic or professional services such as physical therapy, private duty personnel, psychiatric, neurological or geriatric assessments, etc.
- Ambulance service, emergency and all transportation, whether provided by the HOME, public or private carrier.
- Any specialty items requested to be purchased.
- Special maintenance requests or special installations and furniture modification requests.
- All repair of damages or replacement of property resulting from misuse or abuse beyond usual wear and tear.
- Families are encouraged to take the resident to the doctor, medical appointments and/or pick up medications. The HOME does not offer transportation services.

Residents, their representatives and family members who are unable to pay the agreed rates and fees, will be given thirty (30) days' advance notice of termination of residency or services.

Rates for basic covered services are subject to change. Rates are generally reviewed and adjusted annually and residents, their representatives and family members will be given thirty (30) days' advance notice.

E. REFUNDS

Refunds are given on a pro-rated basis for each day a resident does not reside in the HOME following a fourteen (14) day notice of cancellation. No proration or refunds will be given for notices less than (14) days. No refunds will be given for discharges beyond mid-month (15th). Short Stays are not eligible for refunds once the resident is admitted. The family/responsible party is expected to remove all personal belongings and vacate the premises within seventy-two (72) hours of permanent discharge from the HOME. Exception to this may be made based on an individual request or need. If not timely retrieved, the HOME will not responsible for any lost or misplaced items. When qualified, proration will be calculated as follows. $417 per day will be applied for each day occupied and the sum will be subtracted from the monthly fee. The balance will be refunded within 14 days.

Bed Hold

Per state regulations, residents transferred to a hospital or acute setting will be considered discharged. Bed hold options are available. The monthly rent will be held and a prorated amount applied, as applicable, if the resident subsequently does not return.

- Notices not to return beyond the 15th of the month will not be refunded.
- Notices not to return within the first 15 days of the month will be reimbursed at a pro-rated rate.
- If death occurs, a pro-rated amount per day will be applied at point of notice regardless of the time of month. I understand that proof of death must be submitted.

F. PERSONAL BELONGINGS AND VALUABLES

Cash, jewelry and valuables brought into the HOME remain the responsibility of the resident, family or responsible party. It is strongly recommended not to bring items of such value to the HOME. If brought, the HOME is not responsible and shall NOT be held liable for any losses incurred.
Any belongings owned by the resident at the time of their discharge or death will be returned to the responsible party for proper disposition. However, for those without known relatives or whose relatives cannot be located after three (3) months, such valuables will be placed in a fund.

Residents receiving SS/SSI are federally mandated a small monthly allowance for personal use. Residents or their responsible party should ensure proper allowance(s) are being retained in a private account for the benefit of the resident and will be managed by the Resident and/or their responsible party. The HOME shall not be responsible for managing the residents SS/SSI funding.

Clothing and necessary personal belongings brought into the HOME should be clearly labeled with the resident's initials or name. Prior to admission an "Inventory List" shall be made available to assist the resident or responsible party in listing all personal items and clothing being brought into the HOME. In compliance with State regulations, the inventory list must be maintained with current information, thus the list shall be updated by the resident or responsible party whenever items are added or removed from the resident's possession.

Prior approval must be obtained for all electrical appliances requested to bring into the HOME.

G. VISITING HOURS

Visiting hours are from 8am to 6pm daily. Overnight pass for one night possible with clearance. See Administrator for further information.

Visits and gifts of flower bouquets or plants lift the spirits of residents and promote emotional wellbeing. Children are especially welcome.

The HOME encourages visitations, however, visitors who are new or unfamiliar to the staff of the HOME may see residents only after they have checked in with the ARCH Administrator (or designee). To minimize disturbances to others, various public areas of the facility may be used for visitation. To ensure everyone's safety, visitors may see residents in their rooms ONLY with ARCH Administrator (or designee) permission. Whether meeting in a resident's room, or in the public areas, every effort should be made to be mindful of the privacy of other occupants. For the health and well-being of our residents and staff, visitors (including children) with contagious or infectious conditions are not allowed.

H. OUTSIDE VISITS OR LEAVES OF ABSENCES

Residents who demonstrate functional, cognitive and physical ability, are at liberty to leave the HOME's premises for short periods of time once the HOME has received authorization from the resident's Provider, and consent from the primary contact or responsible party.

Overnight stays away from the HOME will require a "Leave Permission Form" to be completed by the responsible party, and provided to the ARCH Administrator (or designee) to ensure proper medications and treatments accompany the resident, and to identify the individual(s) responsible for the resident's well-being while they are away. The ARCH Administrator (or designee) must be notified two (2) days in advance prior to the overnight leave date.

Residents with authorizations not requiring an escort may leave only after they have completed the Sign Out/Sign In Log in the nurses' station, and have notified the ARCH Administrator (or designee) of their destination and expected time of return. Residents without visitor restrictions may leave with family or friends for short periods after filling out the Leave Permission Form. A one (1) day notice is requested and/or ASAP for emergencies.

I. MEDICATION

All resident medications are ordered by their Physician. Medications (prescriptions and over- the-counter medications and supplements) are to be properly labeled and shall be kept in their original containers in designated area. According to Department of Health regulation, no medications are allowed in residents' bedrooms unless authorized by a Provider's Order. Distribution of medications will be handled by nursing staff.

J. FOOD

All resident diets are ordered by their Physician or Dietitian. No food is allowed in residents' bedrooms unless authorized by a Provider's Order. All food items such as fruit, candy, snacks, beverages or other food items brought into the HOME must be cleared with the ARCH Administrator (or designee). Distribution of these items will be handled by designated staff.

K. MAIL, NEWSPAPERS, TELEPHONE, CABLE TELEVISION

All incoming personal mail, messages and packages will be delivered to their respective addressees or forwarded to their responsible party. Permission to open and read the mail to the addressee may be requested from the resident or responsible party. Mail should be addressed in the name of the resident with the HOME's name, street address, city, state and zip code as follows:

Resident's Name
Pohai Malama Care Home
590 Kapiolani Street
Hilo, HI 96720

Residents may subscribe to any newspaper or periodical for their personal use and have it mailed directly to the HOME. Each resident room is pre-wired with telephone and cable television capability already included with monthly fee. Pre-approval must be obtained for personal video and audio equipment and all electrical devices.

Residents may receive or make local telephone calls at any time throughout the day by utilizing the in-house telephones. Staff is available to assist residents in making or receiving in-coming calls or help with their smart devices. Arrangements for brief long distance calls must be made through the ARCH Administrator (or designee) where a log will be kept to ensure proper billing to the resident's account. If a resident desires to video chat with family or friends, appointments can be made with the ARCH Administrator (or designee) for an available time period on the HOME's available smart devices.

L. SMOKING

To protect and enhance air quality, Pohai Malama Care Home is a smoke free campus. Smoking is prohibited throughout all areas, including in the home and all exterior areas on the property and applies equally to all residents, family members, staff and visitors.

No smoking or other use of tobacco, or similar products (including, but not limited to, cigarettes, e-cigarettes or vaping devices, pipes, cigars, snuff or chewing tobacco) is permitted. There are no designated smoking areas on the campus.

M. ROOM ASSIGNMENT, TRANSFER AND DISCHARGE

Residents are located within the facility on the basis of their care needs as determined by their functional abilities, assessed Level of Care and according to availability of requested room type and/or accommodations. Although personal preferences are taken into consideration, assignment to a particular bed or room is neither guaranteed nor permanent. Room changes will be made accordingly as the need arises for each resident and their change in Level of Care (LOC).

Decisions of internal transfer or discharge from the HOME may be made by the HOME's ARCH Administrator (or designee), the resident's Physician and responsible party. Advanced notice will be given to persons who are to be moved or transferred, except in an emergency or unusual circumstance.

State regulations require that all residents who are hospitalized be considered "discharged" from the HOME. Should the resident be hospitalized, the Administrator will work with the resident or responsible party for re-assessment and bed holding options.

Residents unable to adjust to group living or who present continuing behavioral problems that place themselves or others at risk will be discharged.

Except in emergencies or unusual circumstances, thirty (30) days' written advance notice shall be given to residents (or their responsible party) who are to be discharged from the HOME. Residents (or their responsible party) requesting discharge from the HOME must provide a minimum of two (2) weeks written notice to the HOME.

N. BEQUESTS

Residents, other individuals or entities may, of their own volition, leave valuables, properties or cash to Pohai Malama Care Home. Recognized by the IRS as an Exempt Operating Foundation, donations to the HOME are deductible to the extent allowed by law. The ARCH Administrator (or designee) is available to assist with general donations and bequest arrangements.

O. PHOTOGRAPHY GENERAL WAIVER AND RELEASE

A photo release form will be provided at time of admission. The resident or responsible party has the right to privacy and is able to decline or approve a release waiver. Photographs or videotapes may be taken while at the facility or on outings. These photographs or videotapes may be used for identification purposes (medication/treatment books) and displayed within the facility and/or used for the newsletter. Although optional, a signed release/waiver form requesting permission to utilize the resident's picture, likeness, or a video of the resident will be requested during admission.

DISCLAIMER: It is agreed that Pohai Malama Care Home, Hawaii Care Choices and all affiliated entities and employees shall be released from any and all claims, loss or damage to a resident or client's personal property due to incident, accident or misuse. This shall include but not be limited to repair and/or replacement of such property.



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ADMISSION SUITABILITY GUIDE

Pohai Malama Care Home is a licensed Adult Residential Care Home, Type 2 (ARCH II) facility and not a nursing care facility. Those who live here do not need the close or continual supervision and services of licensed medical/health practitioners. To find out if you or the applicant would benefit from the type of services Pohai Malama Care Home offers, please circle **YES OR NO, OR A ONE WORD EXPLANATION** (e.g. SOMETIMES) to assist us in better understanding the applicant's abilities. **There are NO right or wrong answers.**

	DESCRIPTIVE STATEMENT:	YES OR NO
1.	Is alert and aware of his/her surroundings.	YES ☐ NO ☐
2.	Gets lost or wanders away more than once a week.	YES ☐ NO ☐
3.	Is sometimes forgetful but less than twice a week.	YES ☐ NO ☐
4.	OK/safe to be left alone (e.g. Afternoon Nap, Relaxing on Lanai, etc.)	YES ☐ NO ☐
5.	Walks slowly, but without help of any kind.	YES ☐ NO ☐
6.	Needs the help of another person to get out of bed.	YES ☐ NO ☐
7.	Uses cane or walker to get around.	YES ☐ NO ☐
8.	Must be fed by another person.	YES ☐ NO ☐
9.	Able to go to the bathroom alone.	YES ☐ NO ☐
10.	Has frequent bladder/bowel accidents, wears protective undergarments.	YES ☐ NO ☐
11.	Able to feed self or uses assistive eating ware.	YES ☐ NO ☐
12.	Does not walk, usually stays in bed or room.	YES ☐ NO ☐
13.	Can take care of toilet needs when reminded.	YES ☐ NO ☐
14.	Has a skin sore or ulceration.	YES ☐ NO ☐
15.	Is taking medicine/medication by injection.	YES ☐ NO ☐
16.	Is hard of hearing and, if so, wears aides.	YES ☐ NO ☐
17.	Has poor eyesight and, if so, wears glasses.	YES ☐ NO ☐
18.	Wears dentures☐or partial☐ dentures: ☐Uppers ☐Lowers	YES ☐ NO ☐
19.	Has memory loss issues: ☐Short term ☐Long term	YES ☐ NO ☐

Applicant

Print Name	*Signature*	*Date*

Representative/ Guardian

Print Name	*Signature*	*Date*

Pohai Malama Care Home (Representative)

Print Name	*Signature*	*Date*



POHAI MALAMA CARE HOME
590 Kapiolani Street
Hilo, Hawaii 96720

APPLICATION FORM

Name:_____ Date of Application:_____
Last First Middle

Address:_____ City:_____ State:____Zip:_____

☐ Own ☐ Rent ☐ Other - Describe: _____

Gender: F ☐ M ☐ SSN: _____ Marital Status: S ☐ M ☐ W ☐ D ☐

Birthdate: _____ Birthplace: _____

Referred by: Individual ☐ Agency ☐ Physician ☐ Name of Referrer: _____ Reason for Application: ☐ Long Term Placement ☐ Short Stay Services: Dates: _____to _____

Primary Contact/Responsible Person's Name: _____ Relationship: _____

Phone: _____ ☐ Res ☐ Bus ☐ Cell Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Billing Address: Same as above: ☐ Yes ☐ No -IF NO, Address: _____

Secondary Contact Name: _____ Relationship: _____

Phone: _____ ☐ Res ☐ Bus ☐ Cell Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate Contact Name: _____ Relationship: _____

Phone: _____ ☐ Res ☐ Bus ☐ Cell Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Copies of Documents Requested:

☐ Picture ID ☐ Birth Certificate ☐ Social Security Card ☐ Health Insurance Card
☐ Drug Coverage Card ☐ Medicare Card ☐ Medicaid Card ☐ Dental Plan Card
☐ Power of Attorney ☐ Advance Health Care Directive ☐ POLST Form
☐ Funeral Plan: _____

POHAI MALAMA CARE HOME APPLICATION FORM – PART II
Medical Information:

Applicant's Primary Diagnosis and/or Chronic Condition(s): _____

Known Drug/Food Allergies: _____

Health Insurance: _____ Long Term Care Insurance: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____ Fax: _____

Preferred Hospital: _____ Last Hospitalization Date: _____

Admitted for what condition: _____

Personal Information: The following information will aid the staff of Pohai Malama Care Home to better understand the applicant's background and interests:

Are you a U.S. Citizen? ☐ Yes ☐ No Date of Naturalization: _____

MILITARY STATUS: Are you a Veteran? ☐ Yes ☐ No Branch of service: _____

Are you retired from the military? ☐ Yes ☐ No Branch of service: _____

Are you retired federal civil service employee? ☐ Yes ☐ No Age of Retirement: _____

Are you the spouse or dependent of a retired federal civil service employee? ☐ Yes ☐ No

Are you a recipient of VA benefits? ☐ Yes ☐ No

Are you the spouse or dependent of a retired military or veteran? ☐ Yes ☐ No

Former Profession or Occupation: _____ Years: _____

Highest Educational Level or Degree Achieved: _____ Country where educated: _____

Number of Children: _____ Grandchildren: _____ Great Grandchildren: _____

Do you mind if children or teenagers visit the Home? ☐ Yes ☐ No Do you like visitors? ☐ Yes ☐ No

Interests/Hobbies: _____

Skills/Talents *(Musical, Singer, Dancer, Arts & Crafts, etc.)*: _____

Interests: Favorite TV program(s): _____

Favorite Book(s): _____

Favorite Activities: _____

Favorite Food(s): _____

Religious/Church Affiliation: _____

Societal/Other Memberships: _____

Other Comments:

_____

_____

Responsible Person's Signature: _____ Date: _____

FEE SCHEDULE

RESIDENTIAL

Application Processing Fee (one time)	$250
Adult Residential Care Fees:	
Monthly Private Room Rate	
• Private room, with bathroom	$12,500
Monthly Semi-Private Room Rate	*(limited availability)*
• Shared room, with shared bathroom	$10,000
• Two residents per room	
Deposit – 50% of Monthly rent:	
• Private	$6,250
• Semi-private	$5,000
Short Stay Options: **effective 09/01/26*	
• 1 Week (7 days) minimum	$3,450
• 2 Weeks	$6,900
• 3 Weeks (maximum)	$10,350
Daily rate between defined weeks (not to exceed 29 days) $492.86 per day	

All Services: Late Fee assessed $250 per 30 days outstanding

TRANSPORTATION (PHYSICIAN VISITS/MEDICATION) needs to be arranged by Family/Guardian

DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE

LEVEL OF CARE EVALUATION FOR ADULT RESIDENTIAL CARE HOME RESIDENTS

Resident Name _____ SSN _____

Activities of Daily Living	Need for Verbal Reminders/Encouragement (Level /Points 1)	Need for Some Physical Assistance (Level/Points 2)	Need for Ext. /Total Assistance (Level/Points 3)
A. Eating/Feeding	1	2	3
B. Bathing	1	2	3
C. Dressing/Grooming	1	2	3
D. Mobility	1	2	3
E. Transfers	1	2	3
F. Toileting	1	2	3
G. Incontinence-Urine/Feces/Both		1 x /Month	2 x /Month
(Circle appropriate one)		2	3
Total Circled Level Points	_____ =	_____ +	_____ + _____

(If more than 10 points, reassess in total for ARCH level of care.)

Supervision, Behavior Management	NEED FOR OPERATOR ASSISTANCE / INTERVENTION / CONTROLS		
	Less than weekly but at least 1x / month	At least 4x / month	At least 6x / month
A. Impaired Communications	1.5	3	4.5
B. Impaired Judgment	1.5	3	4.5
C. Agitated/Hostile	1.5	3	4.5
D. Hallucinates	1.5	3	4.5
E. Depression	1.5	3	4.5
F. Assaultive/Destructive	1.5	3	4.5
G. Abusive (verbal)	1.5	3	4.5
H. Withdrawn/Regressive	1.5	3	4.5
I. Wanders	1.5	3	4.5
J. Other-Specify: _____	1.5	3	4.5
Total Circled Level Points	_____ =	_____ +	_____ + _____

(If more than 5 points, reassess in total for ARCH level of care.)

Health-Related Services – Per doctor's orders	NEED FOR OPERATOR ASSISTANCE		
	1x / Day	2-3x / Day	4+ x / Day
A. Oral Medication	1	2	3
B. Non-Oral Medication/Dressing/Treatment	1	2	3
C. Special Diet	1	2	3
D. Medical or Psychiatric Appointments/	1x / Month	2-3x / Month	4+x / Month
Transportation/Escort Services	1	2	3
Total Circled Level Points	_____ =	_____ +	_____ + _____

(If more than 6 points, reassess in total for ARCH level of care.)

LEVEL OF CARE ASSESSMENT

(See instructions for Form OHCA ARCH N 2)

ADULT RESIDENTIAL CARE HOME LEVEL	**INTERMEDIATE NURSING CARE LEVEL**	**SKILLED NURSING CARE LEVEL**

_____ _____
Signature of Physician/APRN Date

Prepare 1 copy: Original to Primary Care Giver
Copy to Resident/Responsible Person

OHCA
ARCH N 2
01/07

DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE

RESIDENT ANNUAL PHYSICAL EXAMINATION RECORD

Name: _____ Birth date: _____

Address: _____
Number Street Name City Island Zip Code

Height: _____ Weight: _____ B/P: _____

Eyes: _____ Pupils: _____ Ears: _____

VISION: Right: _____ CORRECT VISION: Right: _____ HEARING: Right: _____
Left: _____ Left: _____ Left: _____

Nose: _____ Mouth: _____ Teeth: _____ Thyroid: _____

HEART: Rate: _____ Rhythm: _____ Murmurs: _____

Lungs: _____ Nervous System: _____

Abdomen: _____ Kidneys: _____

Genitalia/Pelvis: _____ Hemorrhoids: _____

Varicosities: _____ Hernia: _____

Skin: _____ Romberg: _____ Reflexes: _____

Extremities: Upper: _____ Lower: _____

Other abnormalities: _____

Current medications, if any: _____

Resident is ambulatory and capable of following directions and taking appropriate action for self preservation under emergency conditions: ☐ Yes ☐ No

Diagnosis: _____

Diet: _____

Level of Care Assessment:
The Resident is certified as: ☐ **Independent** ☐ **ARCH** ☐ **ICF** ☐ **SNF**

_____ _____ _____
Print or Type Physician/APRN Name | Physician/APRN Signature | Date

OHCA
ARCH I R 19 B
01/07

DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE

SELF PRESERVATION STATEMENT

Name of ARCH _____

I, _____ certify that
(Print physician's name)

_____
(Resident's name)

☐ is ☐ is not ambulatory (*).

He/she ☐ is ☐ is not capable of following directions and taking appropriate action for self-preservation under emergency conditions.

_____ _____
Physician / APRN signature Date

_____
Print or type Physician / APRN name

(*) "Ambulatory" means able to walk without human assistance.

HAR, Title 11, Chapter 100.1, mandates that each resident of a Type I ARCH must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions [refer to section 11-100.1-23(g)(3)(I)].

DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE

VACCINE ADMINISTRATION RECORD

Name: _____ Birthdate: _____

Initial Tuberculosis (TB) Clearance	Test Date		Lot Number		Date Read		Reading (mm) **10mm or > require CXR**	MD/APRN or RN Signature
	Step #1	Step #2	Step #1	Step #2	Step #1	Step #2		
PPD (Mantoux)								

Chest X-Ray (CXR) – Must Attach copy of an official Radiology Chest X-ray Report and/or clearance from the State of Hawaii, Department of Health, Tuberculosis Branch.

Annual Tuberculosis (TB) Clearance	Test Date	Lot Number	Date Read	Reading (mm) **10mm or > require CXR**	MD/APRN or RN Signature
PPD (Mantoux)					

Initial Vaccine	Date Given (mo/day/yr)	Source (F, S, P)	Site	Vaccine		Vaccine Information Statement		Signature/Initials of Vaccinator
				Lot #	Mfr.	Date on VIS	Date Given	
Pneumoccal								
Influenza								
Haemophilus Influenzae Type B								

Annual Vaccine	Date Given (mo/day/yr)	Source (F, S, P)	Site	Vaccine		Vaccine Information Statement		Signature/Initials of Vaccinator
				Lot #	Mfr.	Date on VIS	Date Given	

TB Document F: State of Hawaii TB Clearance Form

Hawaii State Department of Health
Tuberculosis Control Program

Patient Name	DOB	TB Screening Date

I have evaluated the individual named above using the process set out in the DOH TB Clearance Manual dated 2/10/17 and determined that the individual does not have TB disease as defined in section 11-164.2-2, Hawaii Administrative Rules.

Screening for schools, child care facilities or food handlers *(TB Document A or E)*
☐ Negative TB risk assessment
☐ Negative test for TB infection
☐ Positive test for TB infection, and negative chest X-ray

Initial Screening for health care facilities or residential care settings (*TB Document B or C)*
☐ Negative test for TB infection (2-step)
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, negative CXR within previous 12 months, and negative symptom screen
☐ Previous positive test for TB infection, and negative CXR

Annual Screening for Health care facilities or residential care settings (*TB Document D)*
☐ Negative test for TB infection
☐ New positive test for TB infection, and negative chest X-ray
☐ Previous positive test for TB infection, and negative symptoms screen
☐ Previous positive test for TB infection, and negative CXR

Signature or Unique Stamp of Practitioner: _____

Printed Name of Practitioner: _____

Healthcare Facility: _____

This TB clearance provides a reasonable assurance that the individual listed on this form was free from tuberculosis disease at the time of the exam. This form does not imply any guarantee or protection from future tuberculosis risk for the individual listed.

TB Document G: State of Hawaii TB Risk Assessment for Adults and Children

Hawaii State Department of Health
Tuberculosis Control Program

1. Check for TB symptoms

- If there are significant TB symptoms, then further testing (including a chest x-ray) is required for TB clearance.
- If significant symptoms are absent, proceed to TB Risk Factor questions.

☐ Yes ☐ No	**Does this person have significant TB symptoms?** Significant symptoms include <u>cough for 3 weeks or more</u>, plus at least one of the following: ☐ Coughing up blood ☐ Fever ☐ Night sweats ☐ Unexplained weight loss ☐ Unusual weakness ☐ Fatigue

2. Check for TB Risk Factors

- If any "Yes" box below is checked, then TB testing is required for TB clearance
- If all boxes below are checked "No", then TB clearance can be issued without testing

☐ Yes ☐ No	**Was this person born in a country with an elevated TB rate?** Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
☐ Yes ☐ No	**Has this person traveled to (or lived in) a country with an elevated TB rate for four weeks or longer?**
☐ Yes ☐ No	**At any time has this person been in contact with someone with *infectious TB disease*? (Do not check "Yes" if exposed only to someone with latent TB)**
☐ Yes ☐ No	**Does the individual have a health problem that affects the immune system, or is medical treatment planned that may affect the immune system?** *(Includes HIV/AIDS, organ transplant recipient, treatment with TNF-alpha antagonist, or steroid medication for a month or longer)*
☐ Yes ☐ No	**For persons under age 16 only: Is someone in the child's household from a country with an elevated TB rate?**

Provider Name with Licensure/Degree:	**Person's Name and DOB:**
Assessment Date:	**Name and Relationship of Person Providing Information (if not the above-named person):**

PHYSICIAN ORDERS **Name of ARCH:**_____

Resident Name: _____ *Date:* _____
Diet Order: _____
Level of Care: ☐ Independent Living ☐ ARCH ☐ ICF ☐ SNF
Activity Orders: Ambulation: ☐ Ambulatory without Assistance ☐ Walker ☐ Cane ☐ W/C Passes: ☐ May go on a day-pass without Supervision for a maximum period of _____hours. ☐ May go on day-pass with Supervision for a maximum period of _____hours. Restraints: ☐ Seat Belt W/C ☐ Side-rails _____ ☐ Lap Tables ☐ Other: _____
Medications, Vitamins and Supplements: (Please include Drug name, dosage, route, and frequency)
Other:

Date: _____Physician Name / Signature: _____

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