



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

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

Upon acceptance, and prior to moving in, the following documents will be required:

- 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.
- Proof of negative COVID-19 test 72 hours prior to admission date to be processed by a certified lab. (*Home test kits are not acceptable*)
- Proof of COVID-19 vaccination.

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. 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.

D. **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. Minimum stay will be one (1) week and maximum short stay will be three (3) weeks. Short Stay fees must be paid in full prior to residents admission. See fee schedule for 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 10th 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 be 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 6am to 10pm 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 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 <input type="checkbox"/> NO <input type="checkbox"/>
2. Gets lost or wanders away more than once a week.	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Is sometimes forgetful but less than twice a week.	YES <input type="checkbox"/> NO <input type="checkbox"/>
4. OK/safe to be left alone (e.g. Afternoon Nap, Relaxing on Lanai, etc.)	YES <input type="checkbox"/> NO <input type="checkbox"/>
5. Walks slowly, but without help of any kind.	YES <input type="checkbox"/> NO <input type="checkbox"/>
6. Needs the help of another person to get out of bed.	YES <input type="checkbox"/> NO <input type="checkbox"/>
7. Uses cane or walker to get around.	YES <input type="checkbox"/> NO <input type="checkbox"/>
8. Must be fed by another person.	YES <input type="checkbox"/> NO <input type="checkbox"/>
9. Able to go to the bathroom alone.	YES <input type="checkbox"/> NO <input type="checkbox"/>
10. Has frequent bladder/bowel accidents, wears protective undergarments.	YES <input type="checkbox"/> NO <input type="checkbox"/>
11. Able to feed self or uses assistive eating ware.	YES <input type="checkbox"/> NO <input type="checkbox"/>
12. Does not walk, usually stays in bed or room.	YES <input type="checkbox"/> NO <input type="checkbox"/>
13. Can take care of toilet needs when reminded.	YES <input type="checkbox"/> NO <input type="checkbox"/>
14. Has a skin sore or ulceration.	YES <input type="checkbox"/> NO <input type="checkbox"/>
15. Is taking medicine/medication by injection.	YES <input type="checkbox"/> NO <input type="checkbox"/>
16. Is hard of hearing and, if so, wears aides.	YES <input type="checkbox"/> NO <input type="checkbox"/>
17. Has poor eyesight and, if so, wears glasses.	YES <input type="checkbox"/> NO <input type="checkbox"/>
18. Wears dentures <input type="checkbox"/> or partial <input type="checkbox"/> dentures: <input type="checkbox"/> Uppers <input type="checkbox"/> Lower	YES <input type="checkbox"/> NO <input type="checkbox"/>
19. Has memory loss issues: <input type="checkbox"/> Short term <input type="checkbox"/> Long term	YES <input type="checkbox"/> NO <input type="checkbox"/>

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 Respite Services: Dates: _____ to _____

Primary Contact/Responsible Person's Name: _____ Relationship: _____
Phone: _____ <input type="checkbox"/> Res <input type="checkbox"/> Bus <input type="checkbox"/> Cell Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
Billing Address: Same as above: <input type="checkbox"/> Yes <input type="checkbox"/> No -IF NO, Address: _____

Secondary Contact Name: _____ Relationship: _____
Phone: _____ <input type="checkbox"/> Res <input type="checkbox"/> Bus <input type="checkbox"/> Cell Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____
Alternate Contact Name: _____ Relationship: _____
Phone: _____ <input type="checkbox"/> Res <input type="checkbox"/> Bus <input type="checkbox"/> Cell Email Address: _____
Address: _____ City: _____ State: _____ Zip: _____

Copies of Documents Requested:

- | | | | |
|----------------------------------------------|--------------------------------------------------------|-----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Picture ID | <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Social Security Card | <input type="checkbox"/> Health Insurance Card |
| <input type="checkbox"/> Drug Coverage Card | <input type="checkbox"/> Medicare Card | <input type="checkbox"/> Medicaid Card | <input type="checkbox"/> Dental Plan Card |
| <input type="checkbox"/> Power of Attorney | <input type="checkbox"/> Advance Health Care Directive | <input type="checkbox"/> POLST Form | |
| <input type="checkbox"/> 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:** _____

2024 FEE SCHEDULE

RESIDENTIAL

Application Processing Fee (one time)	\$250
Adult Residential Care Fees:	
Monthly Private Room Rate	
<ul style="list-style-type: none"> • Private room, with bathroom 	\$12,500
Monthly Semi-Private Room Rate	<i>(limited availability)</i>
<ul style="list-style-type: none"> • Shared room, with shared bathroom • Two residents per room 	\$10,000
Deposit – 50% of Monthly rent:	
<ul style="list-style-type: none"> • Private • Semi-private 	\$6,250 \$5,000
Short Stay Options: <i>*effective 07/01/24</i>	
<ul style="list-style-type: none"> • 1 Week (minimum) • 2 Weeks • 3 Weeks (maximum) 	\$3,450 \$6,900 \$10,350
Additional Monthly Fee for Level of Care (Acuity)	Additional fees may apply as applicable to Expanded ARCH services. <i>*See Acuity fee schedule.</i>
All Services: Late Fee assessed \$250 per 30 days outstanding	

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

2024 ACUITY FEE SCHEDULE

Determining a Resident's Level of Care (LOC)

During the initial application process, a change in condition or on an annual basis throughout the year(s) following move-in, the State of Hawai'i Department of Health requires that applicants/residents of an Adult Residential Care Home (ARCH) be assessed by their Physician to determine their current level of care. This ensures that services proposed or provided are appropriate to meet the care needs of each individual.

Service Provided and Fees Charged Based on Level of Care (LOC)

Residents assessed at **ARCH LOC** levels 1 through 3 require some assistance with their Activities of Daily Living (ADL's). **Expanded/Intermediate Care (ICF)** residents require increased assistance in areas such as ambulation, behavior management, and ADL's. The highest level of care, **Skilled Nursing (SNF)** requires licensed staff (Registered Nurses or Licensed Practical Nurses) to provide direct nursing services, such as insulin injections or wound care.

As a resident "ages in place", or following an episode resulting in more "acute" or "severe" care needs, a resident may transition to a higher level of care category, which translates into increased costs. Utilizing acuity levels designed and approved by the State of Hawai'i for ARCHs, Pohai Malama Care Home has implemented a "Monthly Acuity Level Fee" which is charged based on the individual resident's acuity LOC. This reflects on the "Fee Schedule" below, and is in addition to the regular monthly service fee or additional fees based on accommodations or state requirements.

Acuity Level	Additional Monthly Fee for Level of Care (Acuity)
Level 1: <10	N/C
Level 2: 10-14 Points on LOC	+ \$200
Level 3: 15-21 Points on the LOC	+ \$400
ICF Level of Care: >21 Points on LOC	+ \$700
SNF Level of Care	+ \$1,000

This information is intended to inform and assist applicants, residents, and interested parties in the understanding of the LOC and subsequent charges. We welcome the opportunity to meet with you to review and discuss any questions you may have regarding the assessment process, results, and LOC fees.



POHAI MALAMA CARE HOME

590 Kapiolani Street
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MONTHLY FEE WORKSHEET

A. Pohai Malama Care Home Monthly Fee

Pohai Malama Care Home provides single room accommodations with bathroom facilities.

The monthly fee is based on what it costs the Home to provide care for each individual. The degree of care required depends on the resident's health and cognitive status.

When an applicant is interviewed for admission, along with family members and/or a Social Worker, that individual's monthly fee will be discussed and determined.

Pohai Malama Care Home Fee – Based on Level of Care:

Additional Fees Based on:

Accommodations:

Acuity Level:

Total Estimated Monthly Service Fee:

B. Applicant's Present Monthly Income:

1. Social Security _____
 2. SSI _____
 3. Retirement/Pension Plans _____
 4. Investments _____
 5. Other Sources _____
- Total Monthly Income: _____

C. Additional Sources of Payment, Real or Personal Assets:

1. Family _____
2. Financial Assistance _____
3. Real Assets (Land/Home) _____
4. Personal Assets _____
5. Other: _____

Total Other Payment Sources: _____

Difference between Monthly Fee and Estimated Payment Sources: _____