



Nursing Facility 45-181 Waikalua Road Kaneohe, Hawaii 96744

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Aloha Family & Friends

Welcome and thank you for your inquiry into our Adult Day Health Program. Attached you will find our Application Form. Please provide as much information as possible.

Please mail the completed application form + \$35.00 application fee (non-refundable) to:

**Ann Pearl Adult Day Health Program**  
**Attention: Sharon Takamori**  
**45-181 Waikalua Rd.**  
**Kaneohe, HI 96744**

After we have received all of the necessary documents from you, we will schedule a personal appointment to finalize the admission process.

We look forward to working with you and your family. Please call Monica Wong, our Admissions Coordinator, at 754-4111 with any questions regarding the application process.

Sincerely,

A handwritten signature in cursive script that reads "John Johnson". The signature is written in black ink and is positioned above the printed name of the administrator.

Administrator

# Ann Pearl Adult Day Health Application Form

**NAME:** \_\_\_\_\_ **Likes to be called:** \_\_\_\_\_ **Sex:**  M  F  
Last Name, First Name Middle Initial

**Days you are requesting for ADH attendance:**  Mon  Tue  Wed  Thurs  Fri

**What do you hope to gain from attending the Ann Pearl ADH Program?** \_\_\_\_\_

## PRIMARY INFORMATION

**Birthdate:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Veteran:**  Y  N **US Citizen:**  Y  N

**Marital Status:**  SI  SEP  DI  WI  MA: \_\_\_\_\_ **# of Children:** \_\_\_\_\_

### Applicant's Address

Number Street Room / Apt. #  
City State Zip Code

Has a Durable Power of Attorney-Health Care or Advanced Health Care been executed?  Y  N

*If YES, Pls provide copy for the chart*

Has a Financial Power of Attorney or Trust been executed?  Y  N

*If YES, Pls provide copy for the chart*

### Responsible Party for Applicant

Name / Relationship (incl resp/legal role if any)  
Number Street Room / Apt. #  
City State Zip Code  
Home Phone # Cell Phone #  
Work Phone # Other Phone #

### Insurance Information:

Medical Insurance Plan: \_\_\_\_\_  
Plan #: \_\_\_\_\_  
Medicare #: \_\_\_\_\_  
Medicaid #: \_\_\_\_\_  
Medicare D (Drug Plan): \_\_\_\_\_

## HEALTH INFORMATION

**Primary Care Physician:** \_\_\_\_\_ **Physician Telephone #:** \_\_\_\_\_

**Uses the following for mobility:**  No device or assistance  W/c  Walker  Cane  Attendant

**Vision:**  Good  Glasses  Blind **Hearing:**  Good  Hearing aid  Partially deaf  Deaf

**Dentures:**  Upper  Lower  Both **Dietary Restrictions:** \_\_\_\_\_

**Recent illness or hospitalizations:** \_\_\_\_\_

**Diagnoses:** \_\_\_\_\_

**Daily medications:** \_\_\_\_\_

## AUTHORIZATION FOR APPLICATION

I hereby authorize my physician to release any medical information to Ann Pearl ADH Program. I understand my \$35 application fee is non-refundable. I understand my application does not guarantee admission to the Adult Day Health Program.

Signature of Applicant or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_