# Hawaii County Office of Aging Consumer Registration Form

HCOA: SAMS2K - 03/11 v.2.1.4

| F. Name | M. I. | L. Name | Suffix |
|---|---|---|---|
| | | | |

Maiden:

AKA:

DOB: ___ / ___ / _____

Phone: ( )

Res. Addr.

City | State | Zip

Mailing Addr.

City | State | Zip

Gender: M F Veteran: Y N D

Reg. Date: ___/___/_____

Marital Status: ( Check One )

- ☐ Divorced
- ☐ Married
- ☐ Legally Separated
- ☐ Single
- ☐ Widowed
- ☐ Unknown

**Understands English?** ☐ Yes ☐ No

If no, ✓ language assistance needed ?

- ☐ Chinese
- ☐ Hawaiian
- ☐ Ilocano
- ☐ Japanese
- ☐ Korean
- ☐ Samoan
- ☐ Spanish
- ☐ Tagalog
- ☐ Visayan
- ☐ Other:

**Receives Social Security?** Yes No

**Financial Status:**

Size of Family Unit: _____

Monthly Income: $_____

Income Below Poverty: Yes No

Census Tract:

Tidal Wave Zone: Yes No

**Is Consumer a U. S. Citizen?**

- ☐ Yes ☐ No
- ☐ Legal resident alien

**Employment Status:**

- ☐ Full-time ☐ Seasonal
- ☐ Part-time ☐ Not employed

**Race :** May select more than one.

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Caucasian ( White, Non-Hispanic)
- ☐ Hispanic/Latino
- ☐ Native Hawaiian/Pacific Islander
- ☐ Unavailable

**Education Level:**

- ☐ No formal schooling
- ☐ Grades K - 8
- ☐ Grades 9 - 11
- ☐ High School or GED Diploma
- ☐ Technical or Trade School
- ☐ Some College
- ☐ Any College Degree
- ☐ Bachelor's Degree
- ☐ Graduate Degree
- ☐ Doctorate Degree
- ☐ Unknown

**Are you a Caregiver?** Yes No

If Yes, how are you related?

**Is a Follow-up Requested?** Yes No

**Nationality:** Circle primary nationality if more than one Race selected.

Asian

- ☐ Asian Indian
- ☐ Chinese
- ☐ Cambodian
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Thai
- ☐ Vietnamese
- ☐ Other Asian

Other _____

☐ Unavailable

Hispanic/Latino

- ☐ Cuban
- ☐ Mexico
- ☐ Puerto Rican
- ☐ Other Hispanic/Latino

Native Hawaiian/Pacific Islander

- ☐ Native Hawaiian
- ☐ Guamanian/Chamorro
- ☐ Samoan
- ☐ Tongan
- ☐ Micronesian
- ☐ Other Pacific Islander

White non-Hispanic

- ☐ Portuguese
- ☐ European
- ☐ Middle East, N. Africa

**ADLS:**
( ✔ Yes, if assistance needed )

- — Eating
- — Dressing
- — Bathing
- — Toileting
- — Transferring
- — Walking

☜ **Total # ✔ Yes**

**IADLS:**
( ✔ Yes, if assistance needed )

- — Preparing Meals
- — Shopping for Personal Items
- — Medication Management
- — Managing Money
- — Using Telephone
- — Doing Heavy Housework
- — Doing Light Housework
- — Transportation Ability

☜ **Total # ✔ Yes**

**Health Impairments (Please ✓ all that apply)**

☐ Allergies ☐ Arthritis ☐ Alzheimer's ☐ Asthma ☐ Parkinson's ☐ High cholesterol ☐ Osteoporosis
☐ Cancer ☐ Cataracts ☐ Chronic Pain ☐ Depression ☐ Diabetes ☐ Emotional ☐ Heart Problems
☐ Hearing ☐ Hypertension ☐ Stroke ☐ Speech ☐ Vision ☐ Other _____

**Notes:**

**Does Client Live Alone?** Yes No ( if no, living arrangement code _____ ) See Field Book

| **Provider:** | **Worker:** | **Care Manager:** |
|---|---|---|
| | | |

Emergency Contact/Relationship: Phone (H): Phone (W):

Address: City: State: Zip:

| | | | |
|---|---|---|---|
| Primary Physician: | | Phone: | |
| Address: | City: | State: | Zip: |
| Consumer has formally authorized release of information? ☐ YES ☐ NO | | | |
| Signature: | | Date: | |

I the above signed person, whose Name and Date of Birth appear within this document, understand that this information is being collected for the HAWAII COUNTY OFFICE OF AGING ( hereinafter referred to as "HCOA"). I hereby grant permission, consent, and authorization to the HCOA to release and disclose all information contained in the Senior Citizen Registration Form, including protected health information, to the HCOA's consultants, contractors, and any other persons or entities involved in the administration, and/or enforcement of its programs and services.

The purpose of this Consent is to comply with any requirements, relating to the use and disclosure of protected health information. The information obtained will be used and disclosed for the purposes of providing information and assistance, reporting, processing, administration, and/or determination of my application for programs and services to the elderly. These programs and services include, but are not limited to, *information and assistance, case management, personal care, day care, homemaker chore, transportation, attendant care, home modifications, home-delivered meals, congregate meals, legal, outreach, and community health development.*

This consent is revocable in writing at anytime. This Consent shall remain valid until written revocation from me is received by the HCOA. It is understood that this Consent constitutes an express waiver of any rule against disclosures otherwise provided by any confidentiality provision of Federal, State, or other applicable law.

I hereby release the County of Hawaii, its officers and employees, and the County of Hawaii's funding sources, agents, attorneys, insurers, consultants, experts, and contractors, from all liability and all claims pertaining to use or disclosure of information, or of any professional opinions, findings, or recommendations as contained in the information, records and reports to which this Consent applies.

| For CSE Use Only: | | | | | | | |
|---|---|---|---|---|---|---|---|
| CSE ID #: | | | | | | | |
| Height: | | Weight: | | Hair Color: | | Eye Color: | |