

Hawaii County Office of Aging Consumer Registration Form



HCOA: SAMS2K - 04/17 v.3.0.1

F. Name		M. I.	L. Name		Suffix
Maiden:		Res. Addr.			
AKA:		City	State	Zip	
DOB: ___ / ___ / _____		Mailing Addr.			
Phone: ()		City	State	Zip	
Gender: M F	Veteran: Y N D	Race : May select more than one. <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian (White, Non-Hispanic) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unavailable		Nationality: Circle primary nationality if more than one Race selected. Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Cambodian <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Thai <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian Other _____ <input type="checkbox"/> Unavailable	
Reg. Date: ___ / ___ / _____					
Marital Status: (Check One) <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown		Education Level: <input type="checkbox"/> No formal schooling <input type="checkbox"/> Grades K - 8 <input type="checkbox"/> Grades 9 - 11 <input type="checkbox"/> High School or GED Diploma <input type="checkbox"/> Technical or Trade School <input type="checkbox"/> Some College <input type="checkbox"/> Any College Degree <input type="checkbox"/> Bachelor's Degree <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Doctorate Degree <input type="checkbox"/> Unknown		Native Hawaiian/Pacific Islander <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian/Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Tongan <input type="checkbox"/> Micronesian <input type="checkbox"/> Other Pacific Islander	
Understands English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, ✓ language assistance needed ? <input type="checkbox"/> Chinese <input type="checkbox"/> Spanish <input type="checkbox"/> Hawaiian <input type="checkbox"/> Tagalog <input type="checkbox"/> Ilocano <input type="checkbox"/> Visayan <input type="checkbox"/> Japanese <input type="checkbox"/> Other: <input type="checkbox"/> Korean <input type="checkbox"/> Samoan				White non-Hispanic <input type="checkbox"/> Portuguese <input type="checkbox"/> European <input type="checkbox"/> Middle East, N. Africa	
Receives Social Security? Yes No Financial Status: Size of Family Unit: _____ Monthly Income: \$ _____ Income Below Poverty: Yes No		Are you a Caregiver? Yes No If Yes, how are you related? Is a Follow-up Requested? Yes No		ADLS: (✓ Yes, if assistance needed) — Eating — Dressing — Bathing — Toileting — Transferring — Walking	
Census Tract: Tidal Wave Zone: Yes No		Health Impairments (Please ✓ all that apply) <input type="checkbox"/> Allergies <input type="checkbox"/> Arthritis <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Asthma <input type="checkbox"/> Parkinson's <input type="checkbox"/> High cholesterol <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Emotional <input type="checkbox"/> Heart Problems <input type="checkbox"/> Hearing <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Speech <input type="checkbox"/> Vision <input type="checkbox"/> Other _____			
Is Consumer a U. S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Legal resident alien		Notes:			
Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Seasonal <input type="checkbox"/> Part-time <input type="checkbox"/> Not employed					
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:
For CSE Use Only:			
CSE ID #:	_____		
Height:	Weight:	Hair Color:	Eye Color:

CONSENT and RELEASE

I, _____, whose Name and Date of Birth appear within this document,
 (print name)

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 Consumer 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.

Consumer has formally authorized release of information? <input type="checkbox"/> YES <input type="checkbox"/> NO
Signature: _____ Date: _____