COUNTY OF KAUAI
AGENCY ON ELDERLY AFFAIRS

Update ☐
Date Registered: _____
Completed by: _____
Information verified by:
☐Birth Certificate ☐Passport
☐Driver's License

CONSUMER REGISTRATION FORM

Mr.
Mrs.
Ms. _____

FIRST NAME AND A.K.A. *(if any)* M.I. LAST NAME SUFFIX

Last Name: _____ First Name: _____ M.I. _____ District: _____

Marital Status ☐ Married ☐ Never Married ☐ Widowed ☐ Separated ☐ Divorced ☐ No Answer		**Gender** ☐ Male ☐ Female	**Birthdate** _____ **Phone** _____
RESIDENTIAL ADDRESS	*House #, Street, Town, State, Zip*		
MAILING ADDRESS ☐ Same as residential	*PO Box, Street, Town, State, Zip*		
EMERGENCY CONTACT	Relationship: ☐ spouse ☐ child ☐ relative/friend/other ☐ primary caregiver Name _____ Address _____ Phone # _____		
ETHNICITY	☐ Hispanic/Latino ☐ Not Hispanic/Latino		
RACE	☐ American Indian/Alaskan Native ☐ Black or African American ☐ White ☐ Asian: ☐ Japanese ☐ Filipino ☐ Chinese ☐ Korean ☐ Vietnamese ☐ Other_____ ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race _____		
INCOME	☐ Receives Social Security ☐ Poverty	Monthly:_____ Number in household supported by this income: ☐ Single ☐ Couple ☐ Three ☐ Four ☐ Other _____	
HOUSEHOLD COMPOSITION	☐ Lives alone ☐ With spouse ☐ With children ☐ With other relatives ☐ With non-relatives		
LIVING ARRANGEMENT	☐ Own home ☐ Children/relative home ☐ Rents home/apartment/room(include rent free) ☐ Elderly Housing Project ☐ Care Home (ARCH) ☐ None of the above		
MEDICAL INSURANCE	☐ Medicare A ☐ Medicare B ☐ Medicaid ☐ Other_____		
PRIMARY PHYSICIAN	*Name*	*Phone Number*	
OTHER INFORMATION	U.S. Citizen? Hawaii Resident? Veteran or Dependent?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
AFFIRMATION OF CLIENT INFORMATION	I certify that the information provided on the intake form is true and accurate. I agree that the County Agency on Elderly Affairs and service provider(s) have the right to verify the stated information at any time. I understand that this information will be kept confidential and will be used for statistical purposes and/or to help me receive any benefits or services to which I may be eligible. I hereby authorize the release of information that has been obtained about me for the above purposes.		

Name of Client (print)_____

Name of Representative if applicable (print), relationship _____

Client or client representative signature_____ Date_____

Rev. 1.2015