HAWAII CENTERS FOR INDEPENDENT LIVING

CONSUMER PROFILE APPLICATION

OFFICE CODE: _________ **STAFF CODE:** ______________

CONSUMER NAME:

____

Last *First* *Middle*

STREET ADDRESS:

____

CITY: ____ **STATE:** ________ **ZIP CODE:** ____________

PHONE (VOICE): ______________________ **PHONE (TTY):** _______________________

GENDER: M F **BIRTHDATE:** ___/___/____ **SSAN:** _____-_____-_____

APPLICATION DATE: ____/____/____ **EXIT DATE:** ____/____/____

MARITAL STATUS

___ 1 Married
___ 2 Never Married
___ 3 Divorced
___ 4 Separated
___ 5 Widowed
___ 6 Other

ETHNICITY

01 ___ African American
02 __ Caucasian
03 __ Chinese
04 __ Filipino
05 __ Guamanian
06 __ Hawaiian/Part Hawaiian
07 __ Hispanic
08 __ Japanese
09 __ Korean
10 __ Micronesian
11 __ Native American
12 __ Samoan
13 __ Southeast Asian
14 __ Tahitian
15 __ Tongan
16 __ Fijiian
17 __ Mixed
99 __ Unknown

LANGUAGE If a caller speaks other languages, check the major language under PRIMARY. Under OTHER, check PRIMARY again plus all others that apply.

PRI	OTHER	
___	___	Cambodian
___	___	Cantonese
___	___	English
___	___	Fijiian
___	___	French
___	___	German
___	___	Hawaiian
___	___	Ilocano
___	___	Japanese
___	___	Korean
___	___	Laotian
___	___	Mandarin
___	___	Portugese
___	___	Samoan
___	___	Spanish
___	___	Tagalog
___	___	Tahitian
___	___	Tongan
___	___	Vietnamese
___	___	Visayan
___	___	American Sign (ASL)
___	___	Other ______________ _________________

DISABILITY If a caller has a disability, check the major disability under PRIMARY. Under OTHER, check all others that apply.

PRI	OTHER	Code	Disability
___	___	100a	Totally Blind (NLP)
___	___	100b	Legally Blind
___	___	100c	Serious Vision Impairment
___	___	100d	Deaf/Blind
___	___	200a	Deaf
___	___	200b	Hearing Impairment
___	___	300a	Speech Impairment
___	___	400a	Amputation
___	___	400b	Arthritis
___	___	400c	Fractures/Injuries resulting in permanent loss/impairment of limb function
___	___	400d	Cerebral Palsy
___	___	400e	Multiple Sclerosis
___	___	400f	Neuromuscular Disease
___	___	400g	Spina Bifida
___	___	400h	Spinal Cord Injury
___	___	400x	Other Orthopedic Impairment
___	___	500a	Head Injury
___	___	500b	Learning Disability
___	___	500c	Developmental Disability (Autism)
___	___	500d	Mental Retardation
___	___	500e	Psychiatric Disability
___	___	500f	Alzheimer's Disease
___	___	500g	Dementia (Mental Deterioration)
___	___	600a	Cancer (Lupus/Lukemia)
___	___	600b	Cardiovascular (Heart Disease/ Heart Attack/By-Pass Surgery)
___	___	600c	High Blood Pressure
___	___	600d	Chemical Dependency
___	___	600e	Diabetes
___	___	600f	Endocrine/Metabolic Condition (digestive problems)
___	___	600g	Kidney Failure (Renal)
___	___	600h	Environmental Sensitivity
___	___	600i	Epilepsy
___	___	600j	Hansen's Disease
___	___	600k	HIV/AIDS
___	___	600l	Neurological Condition
___	___	600m	Respiratory Condition
___	___	600n	Stroke (CVA)
___	___	600x	Other Disability _______________ ______________________________

CONSUMER PROFILE APPLICATION

HOW CONSUMER LEARNED OF SERVICES

1 ___ Self
2 ___ Service Provider
3 ___ Family or Friend
4 ___ Consumer
5 ___ Staff/Board Member
6 ___ Presentation
7 ___ Media
8 ___ Materials
9 ___ Other

When completing the next section, indicate the **situation** of the consumer at the time of intake or exit. Do not indicate what the consumer needs, only their personal circumstances. This section is filled out at the time of application **and** exit.

Intake Exit TYPE OF LIVING SITUATION
(check only one)

___ ___ Primary Care Facility
___ ___ Parent/Guardian Home
___ ___ Boarding Home
___ ___ Family
___ ___ Group Home
___ ___ Transitional Housing
___ ___ Own House/Apartment
___ ___ Renting House/Apartment
___ ___ Hotel
___ ___ Single Room Occupancy
___ ___ Homeless

Intake Exit LIVING CONDITIONS
(check all that apply)

___ ___ Accessible (physical or communication
___ ___ Inaccessible(physical or communication)
___ ___ Subsidized
___ ___ Unsubsidized
___ ___ Living Alone
___ ___ Living with Spouse or Friend
___ ___ Living with Attendant
___ ___ Living with Dependent Child
___ ___ Living with Adult Child
____ ____ Other ________________________________
____

Intake Exit ANNUAL INCOME LEVEL
(check only one)

___ ___ $ 0 -- $ 4,600
___ ___ $ 4,601 -- $ 6,600
___ ___ $ 6,601 -- $10,000
___ ___ $ 10,001 -- $15,000
___ ___ $ 15,001 -- $20,000
___ ___ Over $20,000

Intake Exit HEALTH CARE COVERAGE
(check all that apply)

___ ___ Medicare (A / B / C)
___ ___ Medicaid (# ________________________)
___ ___ Health Insurance Carrier
(Name: ________________________)
___ ___ Aloha Care Quest-Net
___ ___ Queen's Hawaii Care Quest-Net
___ ___ HMSA Quest-Net
___ ___ Tri-Care
___ ___ Kaiser Quest-Net
___ ___ Straub Quest-Net
___ ___ HDS (Medical / Drug / Vision)
___ ___ Hawaii State Health Fund - Drugs
___ ___ Hawaii State Health Fund - Dental
___ ___ Hawaii State Health Fund - Vision
___ ___ Hawaii Laborers Self-Insured Plan
___ ___ Dental Insurance

Intake Exit HEALTH/OTHER SERVICES
(check all that apply)

___ ___ Personal Physician
(Name: ________________________)
___ ___ Nurse Practitioner
___ ___ Psychologist
(Name: ________________________)
___ ___ Physical Therapy
___ ___ Occupational Therapy
___ ___ Speech Therapy
___ ___ Holistic Health Practitioner
___ ___ Public Nurse

Intake Exit PERSONAL ASSISTANCE
(check all that apply)

___ ___ No Caregiver
___ ___ Attendant
___ ___ Spouse
___ ___ Family Member
___ ___ Foster Care
___ ___ Chore Worker
___ ___ Homemaker
___ ___ Visiting Nurse
___ ___ Home/Health Aid

PRIMARY CAREGIVER LOCATION
(complete only if Consumer not primary manager)

PCG Name: ____

Address: ____

____

Intake Exit EMPLOYMENT
(check only one)

___ ___ Full-Time (minimum wage or more)
___ ___ Part-Time (minimum wage or more)
___ ___ Self-Employed Full-Time
___ ___ Self-Employed Part-Time
___ ___ Sheltered Employment
___ ___ Supported Employment
___ ___ Volunteer
___ ___ Not Employed; not seeking work
___ ___ Not Employed; seeking work
___ ___ Retired

CONSUMER PROFILE APPLICATION

Intake Exit INCOME SOURCES
(check all that apply)

___ ___ Job Earnings
___ ___ Family Support (in kind)
___ ___ SSI
___ ___ SSDI
___ ___ Social Security (Retirement)
___ ___ Worker's Compensation
___ ___ Veteran's Benefits
___ ___ General Assistance
___ ___ TANF
___ ___ TAONF
___ ___ Pension
___ ___ IRA/Stocks and Bonds
___ ___ Food Stamps $ ______________________

Intake Exit COMMUNICATION AIDS
(check all that apply)

___ ___ TTY/TDD/Telebrailler
___ ___ Interpreter (Interpreter/ASL)
___ ___ Hearing Aids
___ ___ Assistive Listening Device
___ ___ TV Devices/Systems (CCTV/Aladdin, etc.)
___ ___ Alerting Devices/Systems
___ ___ Computer Assisted Aids
___ ___ Voice Activated Devices
___ ___ Braille
___ ___ Reader
___ ___ Glasses/Magnifiers
___ ___ Augmentive Devices
___ ___ Other ________________________________

Intake Exit HIGHEST EDUCATION ATTAINED
(check only one)

___ ___ No Education
___ ___ Not Graded Special Education
___ ___ 8th Grade or Less
___ ___ Some High School
___ ___ High School Diploma
___ ___ GED
___ ___ Some College
___ ___ College Degree
___ ___ Some Graduate Work
___ ___ Graduate Degree
___ ___ Vocational/Special Education _____________
____

Intake Exit MOBILITY AIDS
(check all that apply)

___ ___ Powered Wheelchair
___ ___ Manual Wheelchair
___ ___ Walker
___ ___ Crutches
___ ___ Cane
___ ___ Guide Dog
___ ___ Braces
___ ___ Prosthetics
___ ___ Other ________________________________

Intake Exit TRANSPORTATION
(check all that apply)

___ ___ Own Vehicle; drives self
___ ___ Own Vehicle; others drive
___ ___ Family/Friend
___ ___ Volunteer
___ ___ Public Transportation w/ Assistance
___ ___ Public Transportation w/o Assistance
___ ___ Subsidized Transportation
___ ___ Agency
___ ___ Van Service: __________________________
____

OUTREACH DETERMINATION: In general, The Outreach Program assists the disabled community (CORE) from Waipahu out the Leeward Coast to Makaha, the Central Valley from beyond Pearl City to Mokuleia, and the North Shore area from Haleiwa to Laie and down the Eastern Shore to Kahalu`u. These individuals are among the unserved and underserved members of the community. If the Consumer cannot come into the HCIL office:

a. Is there a common area where they can be met for an interview (***e.g.,*** business area, shopping center, recreation center, restaurant)? PLACE: ____

b. Do they have a P. O. Box or address where they can be reached by mail so the IL Specialist can contact them by letter? CONTACT: ____PHONE or PAGER: ____________________

c. If emergency funds are required (and the Consumer is not under sanction) but the funds are not available, the Consumer should be told that funds are not available at this time and that those agencies that may have funds will be contacted and the Consumer informed of the results. DO NOT REFER A CONSUMER TO AN AGENCY FOR FUNDS IF THE AGENCY DOES NOT HAVE FUNDS.

d. If housing is required, an IL Specialist will make available a housing list for the area desired according to the Consumer's needs (number of rooms/affordability) can be sent to the Consumer.

NOTE: Pertinent information regarding this contact can be written in the Summary Notes below.

✻ **NOTE**: If emergency funds are required, is the Consumer under sanction? _____ Yes _____ No

Do you have verification of participation in a work training or volunteer program? _____ Yes _____ No

Would you like to be notified about issues that affect the disabled population? _____ Yes _____ No

CONSUMER CONTACT RECORD INFORMATION

	DATE	UNITS	SERVICE CODE	FUNDER CODE	CONTENT CODES	REFERRAL CODES
INTAKE			**01**			
EXIT			**11**			

SUMMARY NOTES:

____

____

____

____

____

____

____

____

____

____

FUNDER CODES

01 Title VII Core
02 State POS Core
03 ILP
04 EBS
05 Fee for Service
99 Other

REASONS FOR SEEKING SERVICES (CONTENT CODES - ABOVE)

AA ___ Architectural Accessibility
AD ___ Advocacy Services
BN ____ Benefits (Section 8/voucher/rent supplement)
CA ___ Communication Accessibility
CD ___ Services for Child w/Disabilities
CH ___ Chore Services
CL ___ Consumer/Legal Rights
CM ___ Communication Devices/Assistance
CS ___ Counseling Services (Peer)
CT ___ Consultant/Technical Assistance
DL ___ Daily Living/Self-Care
EM ___ Employment Counseling
EQ ___ Equipment/Assistive Technology
ER ___ Emergency Resources (food bank/furniture/ appliances/kitchen utensils)
ET ___ Education /Training
FN ___ Finances ❋
HC ___ Health Care/Nutrition
HG ___ Housing Referral
MO ___ Mobility
PA ___ Personal Assistance Services
SH ___ Self-Help/Personal Growth
SR ___ Social/Recreation
TR ___ Transportation
OT ___ Other

____

____

❋ **NOTE:** If emergency funds are required, is the Consumer under sanction: ___ Yes ___ No

REFERRAL CODES

01 Agencies Serving Aging
02 Agencies Serving Children
03 Developmental Dis. Agency
04 Disability Related Org.
05 Education Organization
06 Employment Agency
07 Housing Agency
08 Information Service
09 Legal Service
10 Mental Health Agency
11 Medicaid
12 Medical Service
13 Benefit Granting Agency
14 Primary Care Facility
15 Private Business
16 Private Vendor
17 Protection & Advocacy
18 Rehab Agency- Blind VR
19 Rehab Agency- General IL
20 Rehab Agency- General VR
21 Social Security Admin
22 Transportation Agency
23 Veteran's Administration
24 Welfare Agency
99 Other ____________________
____
____

PURPOSE: To record pertinent data about each Consumer in order to verify that they are eligible for service, to provide more efficient service to them, and to allow them to apply for service with the Agency.

PERSONNEL RESPONSIBLE: Executive Director, HCIL
Deputy Director, HCIL
Program/Branch Coordinators
IL Specialists/Special Program Counselors/CSOs

INSTRUCTIONS:

1. An HCIL Consumer Profile Application Form will be completed on each new Consumer applying for service with HCIL. Consumers must have a permanent disability (either visible or verified by a physician) to receive general CIL services. Eligibility requirements for special programs are covered in the procedures for that program. If a Consumer has been in an inactive status for more than three years, an updated HCIL Consumer Profile Application (Intake) Form will be completed.

(**NOTE**: Until the following information is entered directly into the computer by the IL Specialist/Special Program Coordinator/CSO, it will be typed or written legibly on the form)

a. Enter the Office Code and your Staff Code Number at the top of the form.

b. Enter the Consumer's name on the first line.

c. Enter the actual Address, City/Town, State, full ZIP Code, and the District Code (DC -see below). Fill in the Contact (Voice) phone number, TTY/TDD Number (if appropriate), circle "M" or "F" for gender, the birthdate (digital month/day/year), Social Security Account Number (SSAN), and the digital Application (Intake) Date ***(i.e.,* March 12, 1994 = 03/12/94).** (**NOTE:** If the person uses an alias, nickname, married (maiden) name, or former name (if the name has been legally changed), and/or the individual has a separate mailing address from their actual address, it should be printed or typed on the Change of Address Form.) The exit Date will be left blank until the case closes.

2. **DISTRICT CODES** – All Consumer locations will be identified by ZIP Code.

3. **MARITAL STATUS**: Enter a checkmark in the proper block.

4. **ETHNICITY:** Mark the appropriate block within "." There should be very few times when "OTHER" or "UNKNOWN" are checked. Portuguese is considered to be Caucasian. **NOTE**: Anyone who is part (any part) Hawaiian is listed under Code 06 - not Code 16. There should be very few instances where Codes 17 or 99 are used.

5. **LANGUAGE:** Check the Primary Language under "PRI." Under "ALL" check any other languages that apply. If the language spoken does not appear on the list, check "Other" and print the language or dialect in the space provided.

6. **DISABILITY:** Mark the appropriate block with an "X" in the Column "PRI" (Primary). If the Consumer has more than one permanent disability, place an "X" in the "ALL" column by all other disabilities (***e.g.,*** a Consumer is deaf and has arthritis -- place an "X" in the column "PRI" by Deaf

(200a) and an additional "X" in column "ALL" by Arthritis (400b). **NOTE:** Some disabilities are specifically named or self explanatory. Others are part of a larger group and that category should be used with a note concerning the specific disability written in the Summary Note on Page 4 of the form as well as the Contact Record.

DISABILITY CODES

100
- a - Totally Blind (NLP)
- b - Legally Blind
- c - Serious Vision Impairment
- d - Deaf/Blind (Ushers Syndrome)

200
- a - Deaf
- b - Hearing Impairment

300
- a - Speech Impairment (Aphasia, cleft palate, harelip, stammer/stutter)

400
- a - Amputation
- b - Arthritis (Rheumatism, Rheumatic Fever)
- c - Fractures/Injuries resulting in permanent loss/impairment of limb function
- d - Cerebral Palsy
- e - Multiple Sclerosis
- f - Neuromuscular Disease (Muscular Dystrophy, Lou Gherig's Disease)
- g - Spina Bifida
- h - Spinal Cord Injury
- x - Other Orthopedic Impairment (Osteoporosis)

500
- a - Head Injury
- b - Learning Disability (Dyslexia)
- c - Developmental Disability (Autism)
- d - Mental Retardation (Down’s Syndrome, mongolism)
- e - Psychiatric Disability (Anorexia, Depression)
- f - Alzheimer's Disease
- g – Dementia (Mental Deterioration)

600
- a – Cancer (Lupus/Lukemia)
- b - Cardiovascular (Heart Disease/Heart Attack/By-Pass Surgery/Aneurysm)
- c - High Blood Pressure
- d - Chemical Dependency (Drug/Alcohol)
- e - Diabetes
- f - Endocrine/Metabolic Condition (Hemophilia, Leukemia, Lupus, Varicose Veins/Hemorrhoids/digestive problems)
- g - Kidney Failure (Renal)
- h - Environmental Sensitivity

- i - Epilepsy
- j - Hansen's Disease (Leprosy)
- k - HIV/AIDS
- l - Neurological Condition (Machado's Disease, Polio, Paraplegia/Quadraplegia, Parkinson's Disease)

m - Respiratory/Lung Condition (Cystic Fibrosis, Emphysema, Tuberculosis)
n - Stroke (Hemiplegia/CVA)
x - Other Disability

CONSUMER PROFILE

NOTE: This section of the form is completed at the time of Intake and when all the services have been completed or satisfied. At the time of closure, it becomes a vehicle for the Satisfaction Survey.

7. **TYPE OF LIVING SITUATION:** Check only one of these items at the time of Intake. When services are completed, check only one item. If the type of living situation has **not** changed, check the same block.

8. **LIVING CONDITIONS:** Check each item that is applicable. Note that the first two items apply to the disability of the Consumer (***i.e.,*** if the Consumer is deaf and the facility is not equipped with a TDD or flashing lights, the unit is not accessible).

9. **INCOME SOURCES:** Check each item that is applicable. (**NOTE**: Food Stamps are not income, but the amount will be noted in the space if received)

10. **ANNUAL INCOME LEVEL:** Check the range in which the total of all annual income listed in Item 11, above, falls (***i.e.,*** The Consumer gets $400.00 per month from SSI, $120 per month in a pension, and $50 per month from their parents. The monthly income is $570 x 12 = $6,840 annually. You would mark the third block -- $6,601 - $10,000).

11. **HIGHEST EDUCATION ATTAINED**: Check the item that is most appropriate.

12. **EMPLOYMENT:** Check only one item.

13. **TRANSPORTATION:** "Public Transportation With Assistance" would include the accessible buses in Honolulu, The HandiVan, CIL vans, or other accessible vans -- "Without Assistance" would include those same buses but for a Consumer who does not need to use the lift. "Subsidized Transportation" includes those Consumers who can ride the public system free. It does not include a system in which they have to pay fare for any part of the distance.

14. **PERSONAL ASSISTANCE:** Check all that apply. In those cases where the Consumer may be truly "independent," check Other and insert "NA."

15. **MOBILITY AIDS**: Check all that apply (e.g., a Consumer who uses a guide dog may also use a cane; so both items would be checked). Crutches include those made of wood , metal, or plastic composition. Canes include both the long cane and the support cane (any cane with a handle), and the cane with four feet for support. "Other" could include a special device for driving a car.

16. **COMMUNICATION AIDS:** Check all that apply -- "Interpreter" includes not only one who signs but also one who speaks a language or dialect other than English: if this block is checked for that reason, also write in the language or dialect required. "Assistive Listening Devices" includes tape

recorders, "talking" watches, "talking" books, or any of the other "talking" devices use by the blind or visually impaired. "Television Devices/Systems" includes any listening device used to enhance the sound (with or without volume control), a screen enlarger, the Voyager or any similar system used to enlarge a printed page, or a closed captioning device. "Alerting Devices/Systems" includes flashing lights or sensors installed for the hearing impaired, the "Say When" or other device used by the blind to warn when hot water has filled the cup or tub, timers that ring. "Other" could include the use of the Library for the Blind and Physically Handicapped. the Library of Congress tapes.

17. **HEALTH/OTHER SERVICES:** Enter a checkmark for all that apply (**NOTE:** Fill in the personal physician's name and phone number and/or the psychologist's name and phone number, if appropriate).

18. **HEALTH CARE COVERAGE:** Check all that apply **(NOTE:** Circle the letters that apply under Medicare, and insert the Medicaid Number if applicable).

19. **PRIMARY CAREGIVER LOCATON**: Complete **only** if the Consumer is not the primary manager.

20. **OUTREACH DETERMINATION:** When completing the Consumer Profile Application Form, care should be given to recognize someone who may be served by the Outreach Program. If the person is permanently disabled and meets the geographical requirements, the Summary Notes should reflect that the individual may be served by the Outreach Program (Oahu only).

21. **CONSUMER CONTACT RECORD INFORMATION:** On the first line of the figure (Intake), enter the date of the Intake, the units (15 minutes =1 unit) taken to complete the total Intake process, the Funder Code (The Program that the Consumer will be assigned to - from the list at the bottom of the page) and the Referral Code(s) if the Consumer was referred to another agency for assistance in conjunction with the service we are providing.

22. **SUMMARY NOTES:** Special bits of information not already given on the form should be noted here.

23. When all services have been completed for this Consumer and the case is to be closed, you will fill in the Exit Date at the top of the first page, check off each applicable item under the

Exit" column in the Consumer Profile portion (pages 2 and 3 of the form), and the information on the "Exit" line of the Figure on the last page: the closure date, the units taken to complete the closure (including the Satisfaction Survey), the Funder Code (from the bottom of the page, and Referral Code(s) if the Consumer is being referred to another agency for assistance.

24. When the "Exit" information is completed on the Consumer Profile Application Form (OM-CPA), the form is given to the Program/Branch Coordinator for review together with the completed Satisfaction Survey Form.

25. If Closure is approved, the Program/Branch Coordinator will return these forms (together with other data entry Intake forms) to the IL Specialist/Special Program Counselor for data entry into the CMIS system.

R: 11/15/99