housing, services, and community for LGBT seniors
openhouse

OPENHOUSE REGISTRATION

_____/_____/_____
Date

IDENTIFICATION: Last name:_________________________ First:_________________________

Date of Birth: ____________________ Last 4 digits of SSN: _____________

Address: _________________________City:___________________ State:_____ ZIP:_________

Best phone no. to reach you: _____/_________/________ E-mail: ________________________________

EMERGENCY CONTACT: Last name:______________________ First:_____________________

Relationship: ____

Address: _________________________City:___________________State:_____ZIP:_______

Best phone contact no.: ___________________ E-mail: ______________________________

Please take a few moments to tell us a little more about yourself.
The information you share is CONFIDENTIAL. No identifiable information will be sold or shared.
The information you provide helps us tailor our programs to the needs of the community.
We need to show our funders that LGBT seniors are here!

DEMOGRAPHIC:

Do you identify as (check all that apply): ☐ Lesbian ☐Gay ☐Bisexual
☐ Heterosexual (straight) ☐ Questioning/Unsure ☐ Other __________________________

Do you identify as: ☐ Male ☐ Female ☐ Trans Male ☐ Trans Female
☐ Genderqueer/Gender Non-binary ☐ Other___________________________

What was your sex assigned at birth (check one)? ☐ Male ☐ Female ☐ Intersex

What is your racial/ethnic background? (check all that apply) ☐ American Indian or Alaska Native
☐ Asian, Pacific Islander ☐ African-American ☐ Hispanic/Latino ☐ White/Caucasian
☐ Multi-racial ☐ Other:______________________________

What is your HIV Status? (This information will not be shared outside of Openhouse.)
☐ Negative ☐ Positive ☐ Don't Know ☐ Decline to state

HOUSING: Are you currently looking for housing? ☐ Yes ☐ No
If yes, what is your current monthly rent: $_________________
Would you like to speak with Openhouse about your housing options? ☐ Yes ☐ No

INCOME: *This information is **important** and helps us to **sustain** Openhouse programs.*
Please check your income *range* in the table on right OR fill in the amount below.

What is your approximate individual monthly income before taxes? $____________________.
Do you live alone? ☐ Yes ☐ No

Do you live with a partner or significant other and share expenses? ☐ Yes No
If yes, what is your combined monthly income before taxes?
_____________________.

Client Consent for Release of Information for CAGetCare and among **Service Providers** using CAGetCare

Client Name ________________________________ ________________________________
(Please Print) Last First

Date of Birth _____/_____/_____ Last 4 Social Security # ________________

I, _____________________________________, authorize Openhouse and the Department of Aging and Adult Services/SF Human Services Agency to use and share my demographic information provided on the Openhouse Registration Form and obtained in the course of my receipt of services for the limited purposes of:

- Tracking services;
- Recording enrollment in Openhouse programs;
- Referring me to services that best meet my needs; and
- Preventing the duplication of services among different service providers (requirement for case management program only).

By signing below, I specifically authorize the release of the following classes of information maintained by Openhouse and the CAGetCare database of the Department of Aging and Adult Services/SF Human Services Agency, if such records exist, for the limited purposes set forth above:

- Demographic information
- Benefits information, including Medi-Cal
- Unidentifiable demographic information to Mayor's Office on Housing (MOHCD)—*(if looking for housing)*

NOTE: Completing and signing this form allows us to report to our funders that we are serving LGBT seniors and helps Openhouse to advocate for needed funding.

The information released will be limited to the above identified requested information. This release of information form will be valid for two years upon date of signing. It is further understood that I have been advised that I have the right to revoke this consent at any time.

Signature of Client: ____ Date _____/_____/_____

Agency obtaining information for Consumer Intake Form: Openhouse

San Francisco Human Services Agency, Office on the Aging 875 Stevenson Street, 3rd Floor, San Francisco, CA 94103

FOR OFFICE USE ONLY

Today's date: ______________________ Client ID: ___________________________________

Total Time: _____________ ❒ Circe ❒ GetCare ❒ IR2 ❒ MOHCD

REGISTRATION CONTINUED

(Please complete all fields to the best of your ability. If you don't know an answer, you can leave it blank.)

Caregiving support: Client receives care from a person enrolled in a Family Caregiver Support Program ☐ Yes ☐ No

Language: What is your primary (main) language? ______________________________

What is your English language fluency? ☐ Fluent ☐ Limited ☐ Needs translation

Is your literacy in: ☐ English ☐ Your main language ☐ Both ☐ Not literate

Relationship: What is your relationship status? ☐ Single (Never Married) ☐ Partnered ☐ Domestic Partner ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment: What is your employment status? ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Volunteer ☐ Disabled ☐ Unknown

Veteran Status: Are you a veteran? ☐ Yes ☐ No

2017 Federal Poverty Level = $11,880 or $990 (for 1 person)

Living status: ☐ Urban ☐ Rural Lives alone: ☐ Yes ☐ No

Are you functionally impaired/frail?: ☐ Yes ☐ No ☐ Unknown

Financial status: Is your income?: ☐ At or Below Federal Poverty Level (FPL) ☐Above

Do you receive Social Security? (Title XX)? ☐ Yes ☐ No ☐ Unknown

Do you receive a Private Pension? ☐Yes ☐ No ☐Unknown

Do you receive Supplemental Security Income (SSI)? ☐ Yes ☐ No ☐ Unknown

Do you receive MediCal? ☐ Yes ☐ No

Do you receive Medicare? ☐ Yes ☐ No If yes, do you receive part: ☐ A ☐B ☐ C ☐ D

Legal/Other: Do you have a Guardian/Conservator? ☐ Yes ☐ No

☐ If yes, Name of Person or Organization: ________________________

Type: ☐ Estate ☐ Person ☐ Both ☐ Dementia ☐ Medical Authority

Do you have a Durable Power of Attorney: For **Health**? ☐ Yes ☐ No

For **Finance**? Yes No

Memorializing: Upon your death, would you like an announcement printed in the Openhouse newsletter? ☐ Yes ☐ No

May we print your name in materials for Openhouse memorial events? ☐ Yes ☐No

Medical Contact: Last name:__________________________ First:_______________________

Type of professional: ____

Address: __________________________City:____________________State:_____ZIP:________

Phone(1): ____

Sources of Support: ☐ Family ☐ Friend/Neighbor ☐ Paid Help ☐ Has help but unsure who