

These questions are optional and your answers are confidential. We would like you to tell us your race, ethnicity, language and ability levels so that we can find and address health and service differences.

You can get this document in other languages, large print, braille, or a format you prefer. We accept all relay calls or you can dial 711. Please contact _____ at _____
 Today's Date: _____
 First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____

Race and Ethnicity

1. How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry?**

2. Which of the following describes your **racial or ethnic identity?** Please check **ALL** that apply.

Hispanic and Latino/a/x

- Central American
- Mexican
- South American
- Other Hispanic or Latino/a/x

Native Hawaiian and Pacific Islander

- Chamoru (Chamorro)
- Marshallese
- Communities of the Micronesia Region
- Native Hawaiian
- Samoan
- Other Pacific Islander

White

- Eastern European
- Slavic
- Western European
- Other White

American Indian and Alaska Native

- American Indian
- Alaska Native
- Canadian Inuit, Metis, or First Nation
- Indigenous Mexican, Central American, or South American

Black and African American

- African American
- Afro-Caribbean
- Ethiopian
- Somali
- Other African (Black)
- Other Black

Middle Eastern/North African

- Middle Eastern
- North African

Asian

- Asian Indian
- Cambodian
- Chinese
- Communities of Myanmar
- Filipino/a
- Hmong
- Japanese
- Korean
- Laotian
- South Asian
- Vietnamese
- Other Asian

Other Categories

- Other *(please list)*

- Don't know
- Don't want to answer

3. If you checked **more than one** category above, is there **one** you think of as your **primary** racial or ethnic identity?

- Yes. Please circle your primary racial or ethnic identity above.
- I do not have just one primary racial or ethnic identity.
- No. I identify as Biracial or Multiracial.
- N/A. I only checked one category above.
- Don't know
- Don't want to answer

(To be filled in by agency/clinic staff)

Agency/Clinic: _____ Agency Staff/Provider Name or ID: _____
 Phone: _____ Address: _____

Language (*Interpreters are available at no charge*)

Please skip to question 7 if you/the person is under age 5

4. What language or languages do you use at home? _____

Skip to question 7 if you indicated English only

5a. What language would you prefer to use when communicating (in person, phone, virtually) with someone outside the home about important matters such as medical, legal, or health information?

5b. What language would you prefer to use to read important written information such as medical, legal, or health information?

Skip to question 7 if you do not use a language other than English or sign language

6. How well do you speak English?

- Very Well Well Not Well Not at all Don't know Don't want to answer

Your answers will help us find health and service differences among people with and without functional difficulties. Your answers are confidential. (<i>*Please write in "don't know" if you don't know when you acquired this condition, or "don't want to answer" if you don't want to answer the question.</i>)		Yes	*If yes, at what age did this condition begin?	No	Don't know	Don't want to answer	Don't know what this question is asking
7.	Are you deaf or do you have serious difficulty hearing ?						
8.	Are you blind or do you have serious difficulty seeing , even when wearing glasses?						
Please stop now if you/the person is under age 5							
9.	Do you have serious difficulty walking or climbing stairs ?						
10.	Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions ?						
11.	Do you have difficulty dressing or bathing ?						
12.	Do you have serious difficulty learning how to do things most people your age can learn ?						
13.	Using your usual (customary) language , do you have serious difficulty communicating (<i>for example understanding or being understood by others</i>)?						
Please stop now if you/the person is under age 15							
14.	Because of a physical, mental or emotional condition , do you have difficulty doing errands alone such as visiting a doctor's office or shopping?						
15.	Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations ?						