

NATIONAL AGING PROGRAM INFORMATION SYSTEMS (NAPIS) REGISTRATION FORM

Welcome! We're glad you're here. Would you help us by telling us a bit about you? Services are funded in part by the Older American Act, a federal program since 1965. Annually, we report demographics of participants. All information is confidential. We do not report personal information - only such things as age, gender, race, zip code, poverty, etc.

NAPIS Date

Volunteer

Yes No

Section 1 - Tell us about YOU

Last Name First MI

Phone # Cell # Date of Birth:

Street Address City ZIP

Mailing Address City ZIP

MONTHLY HOUSEHOLD INCOME

HH = 1 \$1,215 or below \$1,216 or above
 HH = 2 \$1,643 or below \$1,644 or above
 HH = 3 \$2,071 or below \$2,072 or above
 HH = 4 \$2,500 or below \$2,501 or above

Veteran: Served in US military?

Self
 Spouse
 Partner/Significant Other
 Child
 No

NUMBER IN HOUSEHOLD

#

Married Widowed
 Divorced Never Married

E-mail:

Section 2 - In case of an emergency, please contact (Optional information)

Contact Name **Phone #**

<input type="checkbox"/> Child	<input type="checkbox"/> Spouse	<input type="checkbox"/> Friend	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Other Family	<input type="checkbox"/> Neighbor	<input type="checkbox"/> Not Related
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Contact Name **Phone #**

<input type="checkbox"/> Child	<input type="checkbox"/> Spouse	<input type="checkbox"/> Friend	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Other Family	<input type="checkbox"/> Neighbor	<input type="checkbox"/> Not Related
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Section 3 - Nutritional Data - Please check all that apply

- I have an illness/condition, and have had to change the kinds (and/or amounts) of food I eat.
- I eat fewer than 2 meals per day.
- I eat few fruits, vegetables, and milk products.
- I have three or more drinks of beer, liquor, or wine almost every day.
- I have teeth (and/or mouth) problems that make it hard for me to eat.
- I do not always have enough money to buy the food I need.
- I eat alone most of the time.
- I take three or more different prescribed (and/or over-the-counter) drugs a day.
- Without wanting to, I have lost or gained 10 pounds in the last six months.
- I am not always physically able to shop, cook, and/or feed myself.

Section 4 - Activities of Daily Living* and Instrumental Activities of Daily Living
 Please mark: I = Independent A = Assistance needed D = Dependent on helper

- | | | |
|--|--|---|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Behavior | <input type="checkbox"/> Dressing |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Elimination/Toileting | <input type="checkbox"/> Mobility/Walking |
| <input type="checkbox"/> Personal Hygiene/Grooming | <input type="checkbox"/> Transferring | <input type="checkbox"/> Food Preparation |
| <input type="checkbox"/> Heavy Housework | <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Managing Finances |
| <input type="checkbox"/> Medication Management | <input type="checkbox"/> Shopping | <input type="checkbox"/> Taking Medications |
| <input type="checkbox"/> Using Telephones | <input type="checkbox"/> Using Transportation | |

Section 5 - Special Diet Needs (Check all that apply)

- | | | | | |
|---|--|-------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Bland | <input type="checkbox"/> Clear Liquid | <input type="checkbox"/> Dairy Free | <input type="checkbox"/> Diabetic | <input type="checkbox"/> High Calorie |
| <input type="checkbox"/> High Fiber | <input type="checkbox"/> High Protein | <input type="checkbox"/> Kosher | <input type="checkbox"/> Liquid | <input type="checkbox"/> Low Calorie |
| <input type="checkbox"/> Low Carbohydrate | <input type="checkbox"/> Low Cholesterol | <input type="checkbox"/> Low Fat | <input type="checkbox"/> Low Fiber | <input type="checkbox"/> Low Sodium |
| <input type="checkbox"/> Low Vitamin K | <input type="checkbox"/> Nasogastric Feeding | <input type="checkbox"/> Renal | <input type="checkbox"/> Soft | <input type="checkbox"/> Supplements |
| <input type="checkbox"/> Thickened Liquid | <input type="checkbox"/> Vegan | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Gluten Free | <input type="checkbox"/> Other |

DISCLOSURE STATEMENT

The following questions are asked to everyone. This is to make sure everyone receives the highest quality of services. You can answer these questions any way you want. You can always choose not to answer a question. Your answers are confidential.

Section 6 - REALD

- How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry?**
- Which of the following describes your **racial or ethnic identity?** Please check **ALL** that apply.

Hispanic or Latino/a/x		American Indian or Alaskan Native		Asian	
<input type="checkbox"/>	Central American	<input type="checkbox"/>	American Indian	<input type="checkbox"/>	Asian Indian
<input type="checkbox"/>	Mexican	<input type="checkbox"/>	Alaska Native	<input type="checkbox"/>	Cambodian
<input type="checkbox"/>	South American	<input type="checkbox"/>	Canadian Inuit, Metis, OR	<input type="checkbox"/>	Chinese
<input type="checkbox"/>	Other Hispanic or Lantino/a/x	<input type="checkbox"/>	Indigenous Mexican, Central American, Or South American	<input type="checkbox"/>	Communities of Myanmar
Native Hawaiian and Pacific Islander		Black and African American		<input type="checkbox"/>	Filipino/a
<input type="checkbox"/>	Chamoru, (Chamorro)	<input type="checkbox"/>	African American	<input type="checkbox"/>	Hmong
<input type="checkbox"/>	Marshallese	<input type="checkbox"/>	Afro-Caribbean	<input type="checkbox"/>	Japanese
<input type="checkbox"/>	Communities of Micronesia	<input type="checkbox"/>	Ethiopian	<input type="checkbox"/>	Korean
<input type="checkbox"/>	Native Hawaiian	<input type="checkbox"/>	Somali	<input type="checkbox"/>	Laotian
<input type="checkbox"/>	Samoan	<input type="checkbox"/>	Other African (Black)	<input type="checkbox"/>	South Asian
<input type="checkbox"/>	Other Pacific Islander	<input type="checkbox"/>	Other Black	<input type="checkbox"/>	Vietnamese
White		Middle Eastern/North African		Other Categories	
<input type="checkbox"/>	Eastern European	<input type="checkbox"/>	Middle Eastern	<input type="checkbox"/>	Other Please List:
<input type="checkbox"/>	Slavic	<input type="checkbox"/>	North African	<input type="checkbox"/>	
<input type="checkbox"/>	Western European	<input type="checkbox"/>		<input type="checkbox"/>	Don't know
<input type="checkbox"/>	Other White	<input type="checkbox"/>		<input type="checkbox"/>	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

4. Language

a. What language or languages do you use at home?

Skip to question 7 if you indicated English only

b. In what language do you want us to communicate in person, on the phone, or virtually with you?

c. In what language do you want us to write to you?

5. Interpreter

a. Do you need or want an interpreter for us to communicate with you?

- Yes
- No
- Don't know
- Don't want to answer

b. If you need or want an interpreter, what type of interpreter is preferred?

- Spoken language interpreter
- American Sign Language Interpreter
- Other (*please list*):
- Deaf Interpreter for Deafblind, additional barriers, or both
- Contact sign language (PSE) interpreter

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 identify health and service differences among people with and without functional difficulties. Your answers are confidential. (*Please write in "don't know" if you don't know when a health change was identified, or "Don't want to answer" if you don't want to answer the question.

	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?						
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?						

	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
12. Do you have serious difficulty learning how to do things most people your age can learn?						
13. Using your usual (<i>customary</i>) language, do you have serious difficulty communicating (for example understanding or being understood by others)?						
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?						

Section 7 - Sexual Orientation and Gender Identity (SOGI) (Check all that apply)

1. Please describe your gender in any way you prefer:

2. What is your gender (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Woman or Girl | <input type="checkbox"/> Not listed/ Please Specify: |
| <input type="checkbox"/> Man or Boy | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Agender/No Gender | <input type="checkbox"/> I don't know what this question is asking |
| <input type="checkbox"/> Non-Binary | <input type="checkbox"/> I don't want to answer |
| <input type="checkbox"/> Questioning | |

3. Are you transgender?

- | | |
|---|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> No | <input type="checkbox"/> I don't know what this question is asking |
| <input type="checkbox"/> Not Listed/Please Specify: | <input type="checkbox"/> I don't want to answer |

4. Please describe your sexual orientation or sexual identity in any way you want.

5. How do you describe your sexual orientation or gender identity? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Same-gender loving | <input type="checkbox"/> Asexual |
| <input type="checkbox"/> Same-sex loving | <input type="checkbox"/> Queer |
| <input type="checkbox"/> Lesbian | <input type="checkbox"/> Questioning |
| <input type="checkbox"/> Gay | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> I don't know what this question is asking |
| <input type="checkbox"/> Straight (attracted mainly to, or only to other gender[s]) | <input type="checkbox"/> Not Listed/ Please Specify: |
| <input type="checkbox"/> Pansexual | <input type="checkbox"/> I don't want to answer |