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 ☐

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	___ $1,133 or below	___ $1,134 or above
HH = 2	___ $1,526 or below	___ $1,527 or above
HH = 3	___ $1,919 or below	___ $1,920 or above
HH = 4	___ $2,313 or below	___ $2,314 or above

NUMBER IN HOUSEHOLD # ☐

___ Married ___ Widowed

___ Divorced ___ Never Married

Veteran: Served in US military?

___ Self
___ Spouse
___ Partner/Significant Other
___ Child
___ No

E-mail: _____

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

Contact Name **Phone #**

☐ Child ☐ Spouse ☐ Friend ☐ Grandchild ☐ Other Family ☐ Neighbor ☐ Not Related

Contact Name **Phone #**

☐ Child ☐ Spouse ☐ Friend ☐ Grandchild ☐ Other Family ☐ Neighbor ☐ Not Related

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

___ Bathing	___ Behavior	___ Dressing
___ Eating	___ Elimination/Toileting	___ Mobility/Walking
___ Personal Hygiene/Grooming	___ Transferring	___ Food Preparation
___ Heavy Housework	___ Housekeeping	___ Managing Finances
___ Medication Management	___ Shopping	___ Taking Medications
Using Telephones	Using Transportation	

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

___ Bland	___ Clear Liquid	___ Dairy Free	___ Diabetic	___ High Calorie
___ High Fiber	___ High Protein	___ Kosher	___ Liquid	___ Low Calorie
___ Low Carbohydrate	___ Low Cholesterol	___ Low Fat	___ Low Fiber	___ Low Sodium
___ Low Vitamin K	___ Nasogastric Feeding	___ Renal	___ Soft	___ Supplements
___ Thickened Liquid	___ Vegan	___ Vegetarian	___ Gluten Free	___ 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**

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

2. 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	
	Central American		American Indian		Asian Indian
	Mexican		Alaska Native		Cambodian
	South American		Canadian Inuit, Metis, OR		Chinese
	Other Hispanic or Lantino/a/x		Indigenous Mexican, Central American, Or South American		Communities of Myanmar
Native Hawaiian and Pacific Islander		Black and African American			Filipino/a
					Hmong
	Chamoru, (Chamorro)		African American		Japanese
	Marshallese		Afro-Caribbean		Korean
	Communities of Micronesian		Ethiopian		Laotian
	Native Hawaiian		Somali		South Asian
	Samoan		Other African (Black)		Vietnamese
	Other Pacific Islander		Other Black		Other Asian
White		Middle Eastern/North African		Other Categories	
	Eastern European		Middle Eastern		Other Please List:
	Slavic		North African		
	Western European				Don't know

☐	Other White		☐	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 *(customary)* 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 you gender in any way you prefer:

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

- ☐ Woman or Girl
- ☐ Man or Boy
- ☐ Agender/No Gender
- ☐ Non-Binary
- ☐ Questioning
- ☐ Not listed/ Please Specify:
- ☐ Don't know
- ☐ I don't know what this question is asking
- ☐ I don't want to answer

3. Are you transgender?

- ☐ Yes
- ☐ No
- ☐ Not Listed/Please Specify:
- ☐ Don't know
- ☐ I don't know what this question is asking
- ☐ 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)

- ☐ Same-gender loving
- ☐ Same-sex loving
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Straight (attracted mainly to, or
- ☐ Asexual
- ☐ Queer
- ☐ Questioning
- ☐ Don't know
- ☐ I don't know what this question is asking
- ☐ Not Listed/ Please Specify:

only to other gender[s])

☐ Pansexual

☐ I don't want to answer