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	1:					
Street Address City	ZIP						
Mailing Address City	ZIP						
MONTHLY HOUSEHOLD INCOME Veteran: Served in US military? HH = 1 \$1,133 or below \$1,134 or above Self HH = 2 \$1,526 or below \$1,527 or above Spouse HH = 3 \$1,919 or below \$1,920 or above Partner/Significant Other HH = 4 \$2,313 or below \$2,314 or above Child MMBER IN HOUSEHOLD # No Number IN HOUSEHOLD # 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 Child Spouse Friend Grandchild Other Family	Phone # 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. 							

Oregon Department of Human Services

Aging and People with Disabilities

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/Walkir			ng			
Personal Hygiene/Gro	Personal Hygiene/Grooming Transferring				Food Preparation				
Heavy Housework	Heavy Housework Housekeepi				Managing Finances				
Medication Managem	Medication Management Shopping				Taking Medications				
Using Telephones		Using Trans	sportation		_				
Section 5 - Special Diet Needs (Check all that apply)									
Bland	Dairy Free		Diabetic	High Calorie					
High Fiber	High Pro	otein	Kosher		Liquid	Low Calorie			
Low Carbohydrate	Low Cholesterol		Low Fat		Low Fiber	Low Sodium			
Low Vitamin K	Nasogas	stric Feeding	Renal		Soft	Supplements			
Thickened Liquid	d LiquidVegan				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.

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	Black and African American	Filipino/a		
Pacific Islander	Diack and American American	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		

seeing, even when wearing glasses? Image: Comparison of the serious difficulty walking or climbing stairs? 9. Do you have serious difficulty walking or climbing stairs? 10. Because of a physical, mental, or emotional	Oregon Department of Human Services			Aging and People with Disabilities					
identity? Yes. Please circle your primary racial or ethnic identity above. I do not have just one primary racial or ethnic identity above. Don't know I do not have just one primary racial or ethnic identity Don't know Don't want to answer No, I identify as Biracial or Multiracial Don't want to answer 4. Language a. What language or languages do you use at home? 5. 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 Spoken language interpreter Other (please list): Contact sign Language interpreter Other (please list): Contact sign language interpreter Well Well Well On't want to answer Your answers will help us identify health and service differences among people with and without functional difficulties, Your answers are conditioned difficulties, Your answers are good. confidential. ("Please write in "don't know" if you don't want to answer Your answers will help us identify thealth and service differences among people with and service differences among people with anot tho answer Your answers will		Other White				Don't want	to answer		
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	10.								
		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 you gender in any way you prefer:

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

		, , ,	
Í		Woman or Girl	Not listed/ Please Specify:
ĺ		Man or Boy	Don't know
ĺ		Agender/No Gender	I don't know what this question is asking
ĺ		Non-Binary	I don't want to answer
ĺ		Questioning	
	3.	Are you transgender?	
		Yes	Don't know
ĺ		No	I don't know what this question is asking

- Not Listed/Please Specify:
- 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)

I don't want to answer



Oregon Department of Human Services only to other gender[s])

Pansexual

I don't want to answer