Oregon Living Well Program

Participant Information

Instructions: Please use a pen to answer the questions on both sides of this form. Please print clearly. Mark your choice within the box, like this: [X]

This information is optional and will help program funders learn if this program is reaching diverse populations and helping people with chronic conditions.

I understand that filling out this form is entirely voluntary.

Please print your initials (First, middle, and last): [ ] [ ] [ ]

1. What is your birth year: [ ] [ ] [ ] [ ] **OR age** [ ] [ ]

Year

2. What county do you live in? _____ (Marion, Deschutes, etc.)

3. What is your gender?

☐ Female ☐ Male ☐ Something else/other_____

4. Are you of Hispanic, Latino, or Spanish origin?

☐ Yes ☐ No ☐ Unknown

5. What is your race? (Mark all that apply.)

☐ American Indian or Alaska Native
☐ Asian or Asian-American
☐ Black or African-American
☐ Hawaiian Native or Other Pacific Islander
☐ White or Caucasian
☐ Something else/other: _____

6. Are you a veteran?

☐ Yes ☐ No

7. What is the highest grade or year of school you completed? (Mark only one.)

☐ Some elementary, middle, or high school
☐ High school graduate or GED
☐ Some college or technical school (1 to 3 years)
☐ College 4 years or more (college graduate)

8. Do you now use tobacco (cigars, cigarettes, smokeless tobacco, etc.)?

☐ Every day ☐ Some days ☐ Not at all

9. Has a health care provider ever told you that you have any of the following chronic conditions? (Mark all that apply.)

☐ Alzheimer's or related dementia
☐ Arthritis/ rheumatic disease/ fibromyalgia
☐ Asthma
☐ Breathing/ lung disease (e.g., COPD, emphysema, bronchitis)
☐ Cancer or cancer survivor
☐ Chronic pain
☐ Depression or anxiety disorder
☐ Diabetes
☐ Heart disease
☐ High cholesterol
☐ Hypertension (high blood pressure)
☐ Multiple sclerosis
☐ Osteoporosis (low bone density)
☐ Stroke
☐ HIV/AIDS
☐ Other chronic condition:
_____
_____
☐ None (no chronic conditions)

10. During the past year did you provide regular care or assistance to a friend or family member who has a long-term health problem or disability?

☐ Yes ☐ No

11. Are you limited in any way in any activities because of physical, mental, or emotional problems?

☐ Yes ☐ No

12. Today, how many people live in your household (including yourself)?

☐ (Number of people)

13. How did you hear about this workshop? (Mark all that apply.)

☐ Doctor, nurse, or other health care provider's office
☐ Health insurance plan
☐ Community or faith-based organization/senior center
☐ Work
☐ Friend/family
☐ Tobacco Quit Line
☐ Newspaper/radio/TV
☐ Internet
☐ Other: _____

14. Do you have health insurance provided through Medicaid (Oregon Health Plan)?

☐ Yes – please check the box next to the name of your plan: ☐ No

- ☐ AllCare
- ☐ Cascade Health Alliance
- ☐ Columbia Pacific Coordinated Care Organization
- ☐ Eastern Oregon Coordinated Care Organization
- ☐ FamilyCare, Inc.
- ☐ Health Share of Oregon
- ☐ Intercommunity Health Network Coordinated Care Organization
- ☐ Jackson Care Connect
- ☐ Pacific Source Community Solutions - Central Oregon
- ☐ Pacific Source Community Solutions - Columbia Gorge
- ☐ PrimaryHealth of Josephine County
- ☐ Trillium Community Health Plan
- ☐ Umpqua Health Alliance
- ☐ Western Oregon Advanced Health
- ☐ Willamette Valley Community Health
- ☐ Yamhill Community Care Organization
- ☐ "Open card" (fee for service)
- ☐ I don't know the name of my OHP plan

15. Do you have health insurance provided through Medicare?

☐ Yes ☐ No

16. Do you have a Medicare Advantage plan?

☐ Yes - check the box next to the name of your plan: ☐ No

- ☐ Atrio
- ☐ CareOregon Advantage
- ☐ CareSource
- ☐ Family Care Health Plans
- ☐ Health Net
- ☐ Humana
- ☐ Trillium Community Health Plan
- ☐ Kaiser Permanente
- ☐ Moda Health Plan
- ☐ PacificSource Medicare
- ☐ Providence Health Plan
- ☐ Regence Blue Cross Blue Shield of Oregon
- ☐ Samaritan Advantage Health Plan
- ☐ United Healthcare
- ☐ I don't know the name of my Medicare Advantage plan

17. Do you have health insurance through any other source?

- ☐ Yes, I have insurance other than Medicaid or Medicare
- ☐ No, I don't have health insurance

Thank You!