

These questions are optional and your answers are confidential. We would like you to tell us *your child's* race, ethnicity, language and disability background so that we can find and address health and service differences.

1. Do you need written materials in an alternate format (Braille, large print, audio recordings, etc.)?
- Yes No Don't know/Unknown Don't want to answer/Decline to answer
- If yes, which format? _____

Race and Ethnicity

2. How does *your child* identify their **race, ethnicity, tribal affiliation, country of origin, or ancestry**?

3. Which of the following describes *your child's racial or ethnic identity*? Please check **ALL** that apply.

American Indian or Alaska Native

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

Hispanic or Latino/a

- Hispanic or Latino Central American
- Hispanic or Latino Mexican
- Hispanic or Latino South American
- Other Hispanic or Latino

Asian

- Asian Indian
- Chinese
- Filipino/a
- Hmong
- Japanese
- Korean
- Laotian
- South Asian
- Vietnamese
- Other Asian

Native Hawaiian or Pacific Islander

- Guamanian or Chamorro
- Micronesian*
- Native Hawaiian
- Samoan
- Tongan*
- Other Pacific Islander

Black or African American

- African American
- African (Black)
- Carribean (Black)
- Other Black

Middle Eastern/Northern African

- Northern African
- Middle Eastern

White

- Eastern European
- Slavic
- Western European
- Other White

Other Categories

- Other (please list) _____
- Don't know/Unknown
- Decline/Don't want to answer

4. If you selected more than one racial or ethnic identity above, please **CIRCLE the ONE that best represents *your child's* racial or ethnic identity.**

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. Contact:

Program:
Phone:
Email:

Language

5. In what **language** do you want us to:

Speak with you _____

Write to you _____

6. Do you need a **sign language** interpreter for us to communicate with you?

Yes Don't know/Unknown

No Decline/Don't want to answer

If yes, which type do you need us to communicate with you?

(ASL, PSE, tactile interpreting, etc.)

7. Do you need an **interpreter** for us to communicate with you?

Yes

Don't know/Unknown

No

Decline/Don't want to answer

8. How well does *your child* speak English?

Very Well Not at all

Well Don't know/Unknown

Not Well Decline/Don't want to answer

Disability Your answers to the questions below help us find health and service differences among people with disabilities or limitations. Your answers are confidential.

9. Is *your child* **deaf** or do they have **serious difficulty hearing**?

Yes Don't know/Unknown

No Decline/Don't want to answer

If yes, at what age did this condition begin? _____

10. Is *your child* **blind** or do they have **serious difficulty seeing**, even when wearing glasses?

Yes Don't know/Unknown

No Decline/Don't want to answer

If yes, at what age did this condition begin? _____

11. Does a **physical, mental, or emotional condition limit *your child's* activities** in any way?

Yes Don't know/Unknown

No Decline/Don't want to answer

If yes, at what age did this condition begin? _____

12. What is *your child's* age today? _____

Please stop now if your child is under age 5

13. Does *your child* have serious difficulty **walking or climbing stairs**?

Yes Don't know/Unknown

No Decline/Don't want to answer

If yes, at what age did this condition begin? _____

14. Does *your child* have **difficulty dressing or bathing**?

Yes Don't know/Unknown

No Decline/Don't want to answer

If yes, at what age did this condition begin? _____

15. Because of a **physical, mental, or emotional condition**, does *your child* have serious difficulty:

a. **Concentrating, remembering, understanding, or making decisions?**

Yes Don't know/Unknown

No Decline/Don't want to answer

If yes, at what age did this condition begin? _____

Please stop now if your child is under age 15

b. **Doing errands alone** such as visiting a doctor's office or shopping?

Yes Don't know/Unknown

No Decline/Don't want to answer

If yes, at what age did this condition begin? _____