Client Identification

Program # _____

ID # _____

Enrollment Date _____ (mm/dd/yyyy)

IOWA Health and Human Services Public Health

Complete this form once per year at annual enrollment. Please PRINT all information.

Last Name _____

First Name _____ Middle Initial _____

Address _____

City _____

State _____ Zip Code _____ County of Residence _____ *(001 – 099, or 111 for outside Iowa)*

Phone _____ *(XXX) XXX-XXXX* Email _____

What is the primary language spoken in your home:

- ◯ 1. English
- ◯ 2. Spanish
- ◯ 3. Arabic
- ◯ 4. Chinese
- ◯ 5. French
- ◯ 6. Italian
- ◯ 7. Japanese
- ◯ 8. Korean
- ◯ 9. Polish
- ◯ 10. Russian
- ◯ 11. Tagalog
- ◯ 12. Vietnamese
- ◯ 13. Creole
- ◯ 14. Portuguese
- ◯ 15. Hmong
- ◯ 16. Other _____

Do you want to receive written health information in:

- ◯ 1. English
- ◯ 2. Spanish
- ◯ 3. Vietnamese
- ◯ 4. Other _____

Gender Identity *(mark only one option)*:

- ◯ 1. Female
- ◯ 2. Trans Man
- ◯ 3. Trans Woman
- ◯ 4. Other _____
- ◯ 5. Don't Know
- ◯ 6. Refused

Sexual Orientation *(mark only one option)*:

- ◯ 1. Straight or Heterosexual
- ◯ 2. Lesbian
- ◯ 3. Gay
- ◯ 4. Bisexual
- ◯ 5. Other _____
- ◯ 6. Don't Know
- ◯ 7. Refused

Client Demographic Information

1. First time ever enrolled in the Iowa Care for Yourself program?
   - ◯ 1. Yes
   - ◯ 2. No *(continue with questions 2-5)*

1a. Birth Date _____ *(mm/dd/yyyy)*

1b. Maiden Name _____

1c. Hispanic or Latina Origin?

◯ 1. Yes ◯ 2. No ◯ 3. Unknown

Please answer 1d-1i to identify your race

Yes	No	Unknown	
◯	◯	◯	1d. White
◯	◯	◯	1e. Black or African American
◯	◯	◯	1f. Asian
◯	◯	◯	1g. Native Hawaiian or Pacific Islander
◯	◯	◯	1h. American Indian or Alaska Native
◯	◯	◯	1i. Some other race

(Continue with questions 2-5)

2. Health Insurance *(mark only one option)*
   - ◯ 1. None
     - 1a. Date referred to insurance *(mm/dd/yyyy)* _____
   - ◯ 2. Insurance *(Includes Medicare Part B)*
   - ◯ 3. Medicare A *(not Part B)*
   - ◯ 4. Under-insured *(Assistance with co-pay and/or high deductible)*
3. Monthly Income $ _____
4. Family Unit Size _____
5. Education (check highest level attained)
   - ◯ 1. Less than 9th grade
   - ◯ 2. Some high school
   - ◯ 3. High school graduate or equivalent
   - ◯ 4. Some college or higher
   - ◯ 5. Don't know/Not sure

Client Medical History

6. Have you had breast cancer?
   - ◯ 1. Yes
   - ◯ 2. No
   - ◯ 3. Don't know/Not sure
7. Has your mother, grandmother, aunt, sister, or daughter had breast cancer?
   - ◯ 1. Yes
   - ◯ 2. No
   - ◯ 3. Don't know/Not sure

8. Have you had a hysterectomy?

- ◯ 1. Yes
  - 8a. Due to cervical cancer? ◯ 1. Yes ◯ 2. No ◯ 3. Unknown
  - 8b. Cervix present? ◯ 1. Yes ◯ 2. No ◯ 3. Unknown
- ◯ 2. No
- ◯ 3. Don't know/Not sure

Client Smoking History

9. Smoking History *(mark only one option)*:

- ◯ 1. Current Smoker
- ◯ 2. Quit (1-12 months ago)
- ◯ 3. Quit (More than 12 months ago)
- ◯ 4. Never Smoked

10. About how many hours a day, on average, are you in the same room or vehicle with another person who is smoking?

- ◯ Hours ☐
- ◯ Less than one
- ◯ None

To be completed by Program Coordinator: (for 1-3 check all that apply)

11. Client:

- ◯ 1. Fax referral to a proactive Quitline (check only one of a or b)
  - ◯ a. Signed by participant
  - ◯ b. Verbal confirmation provided
- ◯ 2. Referred to a local community-based cessation program
- ◯ 3. Provided Quitline contact information
- ◯ 4. Not referred to Quitline or community cessation program or provided Quitline contact information
- ◯ 5. Refused any referral or information