MyCare
HEALTH CENTER

Patient Name: _____ Date of Birth _____
Provider Name: _____

Patient Questionnaire

We must collect statistics on all the patients we serve because we receive Federal grant funds. Your personal information will be held in the strictest of confidence and is only reported in aggregate form. You have the right to refuse to give this information, however, it may limit the services or programs we are able to deliver to you.

Need affordable Health Insurance or Dental Care? We can help!

1. We assist the uninsured & underinsured obtain health insurance; such as, enrollment in the Market Place Plans or Dental Care. Please indicate which you have interest in. Health Insurance _____ Dental Insurance _____

2. Is English your primary language? ☐ Yes ☐ No
If **NO**, what language are you best served in? (This includes sign language or the need for TTY device). _____

3. Please check any living situation you have experienced in the past 12 months:
- ☐ I live in my home which I rent, lease or own.
- ☐ I am staying with friends and/or family members on a temporary basis.
- ☐ I am staying in supportive or transitional housing (such as a sober living facility or recovery home).
- ☐ I live in a public or private facility that provides temporary shelters (such as a shelter, mission, single room or motel).
- ☐ I have been released from an institution (such as jail or hospital) without stable housing to return to.
- ☐ I live on the streets, in a car, park, sidewalk, in an abandoned building, or any other unstable or non-permanent situation.
- ☐ I live in foster care.

4. Are you a Seasonal Agricultural Worker or Migrant Farmer? ☐ Yes ☐ No

5. Are you active or reserve military? ☐ Yes ☐ No Are you a veteran? ☐ Yes ☐ No

6. Are you employed? ☐ Yes ☐ No Full/Part _____ Student? ☐ Yes ☐ No Full/Part _____

7. Are you Retired? ☐ Yes ☐ No Are you Disabled? ☐ Yes ☐ No

8. MyCare offers a Patient Portal where patients can enroll by email to download lab results, request medication refills, pay bills online and much more. Please share your email address if you are interested in using or learning more about this service.
_____

9. Would you like information on Advance Directives? ☐ Yes ☐ No

10. How did you hear about MyCare? ☐ Friend/Family ☐ Social Media ☐ Community Organization ☐ Insurance Company ☐ Hosp/ ER/ Urgent Care ☐ Another MyCare Service ☐ Community Event

11. How many members are in your household (including yourself)? _____ What is your approximate annual income? _____

12. Are you Hispanic or Latino? ☐ Yes ☐ No

Please check the most appropriate box for the following:

13. Race

Asian	☐
Native Hawaiian	☐
Other Pacific Islander	☐
Black African American	☐
American Indian/Alaska native	☐
White	☐
More than one race	☐

14. Sexual Orientation (18 and older)

Lesbian or Gay	☐
Straight (Not Lesbian or Gay)	☐
Bisexual	☐
Something Else	☐
Don't Know	☐
Choose Not To Disclose	☐

15. Gender Identity (18 and older)

Male	☐
Female	☐
Transgender Male (female to male)	☐
Transgender Female (male to female	☐
Other	☐
Choose Not To Disclose	☐

Thank you for your participation. Your answers will help us continue to provide high quality care and services that best meet your needs!

Patient Signature: _____ Date: _____