VGMHC Annual Verification Form

Virginia Garcia Memorial HEALTH CENTER

① WHO ARE YOU? (Patient) The information on this form should be about the patient.

First Name | Middle Name | Last Name | Suffix

Preferred Name | Social Security Number (if available) | Date of Birth

Veteran Status: ☐ U.S. Veteran ☐ Not U.S. Veteran

② HOW CAN WE REACH YOU? (Patient or the patient's parent, guardian, or authorized representative)

Address | Apartment # | City | State | Zip Code

Cell Phone | Other Phone | E-mail

Best way to contact you (mark all): ☐ Mail ☐ Phone ☐ E-mail ☐ MyChart ☐ Text Message

③ RACE AND ETHNICITY (this information helps Virginia Garcia make sure everyone receives access to the same care)

1. How do you define your race, ethnicity, tribal affiliation, country of origin or ancestry? _____

2. Which of the following describes your racial identity? Please check all the apply.

Hispanic and Latino/a/x
- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian and Pacific Islander
- ☐ CHamoru (Chamorro)
- ☐ Marshallese
- ☐ Communities of the Micronesian Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

White
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

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

Black and African American
- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Other Black

Middle Eastern/North African
- ☐ Middle Eastern
- ☐ North African

Asian
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Other Categories
- ☐ Other (please list) _____
- ☐ Don't know
- ☐ Don't want to answer

3. If you checked more than one box above, is there one you think of as your primary racial or ethnic identity?
- ☐ Yes (please circle your primary racial or ethnic identity)
- ☐ I do not have one primary racial or ethnic identity
- ☐ No. I identify as Biracial or Multiracial.
- ☐ N/A. I only checked one box above.
- ☐ Don't know
- ☐ Don't want to answer

VGMHC Annual Verification Form

④ Tell Us How we Can Best Serve You (this information helps Virginia Garcia provide the right resources for you)

Language

4a. What language or languages do you use at home?

_____

4b. In what language do you want us to communicate in person, on the phone, or virtually with you?

_____

4c. In what language do you want us to write to you?

_____

5a. Do you need or want an interpreter for us to communicate with you? Interpreters are free to you.

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer

5b. If you need or want an interpreter, what type of interpreter is preferred?

☐ Spoken language interpreter
☐ American Sign Language interpreter
☐ Deaf Interpreter for DeafBlind, additional Barriers, or both
☐ Contact sign language (PSE) interpreter
☐ Other (please list): _____

6. How well do you speak English?

☐ Very Well ☐ Not at All
☐ Well ☐ Don't know
☐ Not Well ☐ Don't want to answer

The following questions will help us find health and service differences among people with and without functional difficulties. Your answers are confidential.

7. Are you deaf or do you have serious difficulty hearing?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

8. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

If patient is under 5 years old, skip to Section 5

9. Do you have serious difficulty walking or climbing stairs?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

10. Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

11. Do you have difficulty dressing or bathing

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

12. Do you have serious difficulty learning how to do things most people your age can learn?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

13. Using your usual (customary) language, do you have serious difficulty communicating, (for example understanding or being understood by others)?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
☐ I don't know what this question is asking
If yes, at what age did this condition begin? ____

If patient is under 15 years old, skip to Section 5

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?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
If yes, at what age did this condition begin? ____

15. Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?

☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer
☐ I don't know what this question is asking
If yes, at what age did this condition begin? ____

⑤ Tell Us More About You (this information helps Virginia Garcia address you correctly and recommend the right care)

16. Sexual Orientation: ☐Straight or Heterosexual ☐Gay ☐Lesbian ☐Bisexual ☐Pansexual ☐Queer ☐Something else ☐Don't know ☐Choose not to answer

17. Gender Identity: ☐Female ☐Male ☐Trans Woman ☐Trans Man ☐Non-binary/genderqueer ☐Questioning ☐Choose not to answer ☐Other _____

18. Sex assigned at birth: ☐Female ☐Male ☐Intersex ☐Choose not to answer

19. Preferred Pronoun: ☐She/her ☐He/him ☐They/them ☐Use my name ☐Choose not to answer ☐Other _____

Virginia Garcia Memorial HEALTH CENTER

VGMHC Annual Verification Form

⑥ **AGRICULTURAL WORK AND HOUSING STATUS** (This information helps Virginia Garcia provide appropriate outreach services)

20. Have you or a member of your family that you live with *ever* done agricultural work as your main job?
(Agricultural work includes: work in fields, orchards, greenhouses, nurseries, fisheries, working with animals, etc.)

☐ No → **STOP (skip to question 21)**
☐ Yes → Have you or members of your family that you live with moved in the last 2 years to work in agriculture?
- ☐ Yes → **STOP** Staff mark as MFW
- ☐ No → Have you or family you live with done seasonal work in the last 2 years in agriculture without moving?
  - ☐ Yes → **STOP** Staff mark as SFW
  - ☐ No → Did you or family you live with stop working in agriculture because of disability or old age?
    - ☐ Yes → **STOP** Staff mark MFW
    - ☐ No → **STOP** Staff mark NEITHER

21. Last night did you sleep on the street, in a park, under a bridge, in a tent, in a vehicle, in a homeless camp, in a shelter, in an abandoned building, in a motel paid for by the government, in transitional housing, or with friends or family but are not a permanent resident in the home (couch surfing) or other unstable housing situation?

☐ Yes → Staff mark HMLS
☐ No → Last night were you in jail, a treatment center, hospital, or other facility with no place to go when released?
- ☐ Yes → **STOP** Staff mark HMLS
- ☐ No → **STOP** Staff mark NOT HMLS

Access to food, transportation, and other basic supports affect your health. The questions below focus on this. Your answers may help us provide better medical care and we may be able to connect you with more services.

1. What is your living situation today? (Select all that apply)

I have a steady place to live	I have a steady place to live but I'm worried about losing it	I do not have a steady place to live	Declined

2. Within the last 12 months, you worried that your food would run out before you got money to buy more.

Often true	Sometimes true	Never True	Declined

3. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

Yes, has kept me from medical appointments, or getting medications	Yes, it has kept me from non-medical meetings, appointments, work or getting things that I need	No	Declined

4. In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?

Yes	No	Already shut off	Declined

5. How often do you see or talk to people that you care about and feel close to?

Less than once a week	1-2 times a week	3-5 times a week	6 or more times a week	Declined