



Applicant/Enrollee Name: \_\_\_\_\_

PHP (HMO SNP) wants to be sure you get the best care possible. Please answer these questions about your identity by checking the appropriate box. Your answers will help us meet your needs and provide the highest quality of care. Note that if you choose not to complete this questionnaire, your current or future enrollment in the plan will not be affected.

1. What is your race? *Check all that apply.*

<input type="checkbox"/> American Indian and Alaska Native	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Asian	<input type="checkbox"/> White
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Other _____
<input type="checkbox"/> Filipino	<input type="checkbox"/> <i>Decline to State</i>

2. Are you of Hispanic, Latino or Spanish Origin?

<input type="checkbox"/> No	<input type="checkbox"/> Yes, Cuban
<input type="checkbox"/> Yes, Another Latino or Spanish Origin (Argentinean, Peruvian, etc) <i>Print Origin</i> _____	<input type="checkbox"/> Yes, Mexican, Mexican American
	<input type="checkbox"/> Yes, Puerto Rican
	<input type="checkbox"/> <i>Decline to State</i>

3. In which language do you prefer to receive your medical care? *Choose only one.*

<input type="checkbox"/> American Sign Language	<input type="checkbox"/> Mandarin
<input type="checkbox"/> Cantonese	<input type="checkbox"/> Spanish
<input type="checkbox"/> Creole	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> English	<input type="checkbox"/> Other _____
<input type="checkbox"/> Korean	<input type="checkbox"/> <i>Decline to State</i>

4. In which language do you prefer to read? *Choose only one.*

<input type="checkbox"/> Braille	<input type="checkbox"/> Mandarin
<input type="checkbox"/> Cantonese	<input type="checkbox"/> Spanish
<input type="checkbox"/> English	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> French	<input type="checkbox"/> Other _____
<input type="checkbox"/> Korean	<input type="checkbox"/> <i>Decline to State</i>

5. What is your gender?

<input type="checkbox"/> Female	<input type="checkbox"/> Transgender Male (FtM)
<input type="checkbox"/> Male	<input type="checkbox"/> Other _____
<input type="checkbox"/> Transgender Female (MtF)	<input type="checkbox"/> <i>Decline to State</i>

*PHP is an HMO plan with a Medicare contract. Enrollment in PHP depends on contract renewal.*