

## Participant Information Form

<b>First Name</b>		<b>Last Name</b>	
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<b>Gender (circle one)</b>		<b>Birth Date (MM/DD/YYYY)</b>
Male	Female	

<b>Mailing Address</b>		
<b>City</b>	<b>State</b>	<b>Zip Code</b>

<b>Phone Number (XXX-XXX-XXXX)</b>	<b>Email Address</b>

**Have you ever been told by a health professional that you have any of the following chronic conditions:**

**Check all that apply:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Breathing/Lung Disease |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Hypertension           |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Osteoporosis           |
| <input type="checkbox"/> Other Disease |   |   |

Through the Montana Cancer Control Programs, women who are of age and income eligible can access free mammogram and pap test services in their communities. Call toll free **1-888-803-9343**.

<b>Have you ever served on active duty in the United States Armed Forces, either in the regular military or in a National Guard or military reserve unit?</b>	Yes	No
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<b>To indicate your answer check "Yes" or "No" in the appropriate boxes:</b>	<b>Yes</b>	<b>No</b>
Are you deaf or do you have serious difficulty hearing?		
Are you blind or do you have serious difficulty seeing?		
Do you have serious difficulty walking or climbing stairs?		
Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?		

***The Montana Department of Public Health and Human Services is committed to providing access to its programs for people of all abilities. Please let your program leader know if you need any accommodations.***

<b>Do you currently smoke or use other tobacco products?</b>	Yes	No
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<b>Do you have any health insurance?</b>	Yes	No
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**If yes, check all that apply:**

- Medicare                       Medicaid                       Medicaid Expansion (HELP)  
 Private Insurance               Veterans                       Other Insurance

**Racial/Ethnic Background:** Check all that apply.

- American Indian/ Alaska Native               Asian/ Asian-American  
 Black/ African-American                       Hispanic/ Latino  
 Hawaiian Native/ Pacific Islander               White/ Caucasian  
 Other Race

**What is the highest level of education you have completed?** Check only one.

- Less than high school                       Some high school  
 High school graduate                       Some college or vocational school  
 College graduate                       Graduate school

**How did you find out about this program?** Check all that apply.

- Flyer                       Friend/ Family                       Health Care Provider  
 Mailing                       Newsletter                       Newspaper  
 Television                       Website                       Radio  
 Medicaid Expansion (HELP)  
 Other: \_\_\_\_\_

The information collected on the Participant Information Form, the Participant Starting Self-Test, and the Participant Follow-up Self-Test will be protected for your privacy. Total number of participants within various demographic subgroups will be shared with the Centers for Disease Control and Prevention (CDC) as a required deliverable for cooperative agreement #1U58DP003985-01. De-identified aggregate measures may also be used to demonstrate the value of these programs to State and Federal policy makers and community organizations that may be interested in providing the programs in the future. No personally identifying information will be shared with any entity outside of the Montana Department of Public Health and Human Services.