Geriatric Workforce Enhancement Program

Funding for this video was provided through a federal grant from HRSA. We must submit periodic progress reports to the funding agency. Please help us by completing the demographic information and evaluation sections on this form. Please mail back to us at: GWEP 347 N. Kuakini Street, HPM-9, Honolulu, HI 96817. Thank you.

Rev 12-19-17

FULL NAME (optional): __________________________________________

Please indicate your ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Please mark your race (CHECK ALL THAT APPLY): □ White-Non-Hispanic □ White-Hispanic □ Black or African American □ American Indian or Alaska Native □ Native Hawaiian/Other Pacific Islander □ Asian, specify__________________________ □ Other, specify__________________________ □ Mixed, specify__________________________

Veteran Status? □ Veteran □ Not a veteran

What was your residential background before age 18? □ Rural □ Urban □ Suburb

What is your current residential status? □ Rural □ Urban □ Suburb

Are you from a disadvantaged background? □ Yes □ No

What is your gender? □ Male □ Female

What is your age group? □ 20-29 □ 30-39 □ 40-49 □ 50-59 □ 60 and up

Please mark your highest degree or training: □ Elementary/secondary school □ Diploma □ Associates Degree □ Baccalaureate Degree □ Masters Degree □ Doctorate □ MD □ DO □ Other __________________

Are you currently working? □ Yes □ No What is/was your profession? ____________________

For Family/Unpaid Caregivers:

Are you a person with dysphagia? □ Yes □ No Are you a person with memory loss? □ Yes □ No

Are you a family or unpaid caregiver? □ Yes □ No Who are you caring for? ____________________

How many years have you been a caregiver? ______ Are you the PRIMARY caregiver □ Yes □ No

Do you care for someone with dysphagia? □ Yes □ No Do you care for someone with memory loss? □ Yes □ No

Because of this training:

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutra l</th>
<th>Disagre e</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am better able to manage my own stress about helping my loved one or patient eat and drink</td>
<td></td>
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<tr>
<td>I am better able to prepare foods that the person I care for my loved one can eat or drink safely</td>
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<tr>
<td>I know more about positioning the person I care for my loved one during eating and drinking</td>
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<tr>
<td>I feel empowered to manage challenges in</td>
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</tbody>
</table>
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<table>
<thead>
<tr>
<th>providing food and liquids for the person I care for.</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>I understand that tube feeding may not help people with advanced dementia.</td>
<td></td>
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<tr>
<td>I feel comfortable about focusing on quality of life towards the end of life.</td>
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</tbody>
</table>

*Will your practice or caregiving change as a result of what you learned in this training?*  [ ] Yes  [ ] No  [ ] Not applicable

*What other topics would you like to learn about?*

__________________________________________________________