1. Are you ________
   □ Male
   □ Female

2. What language do you speak at home? ______________________

3. What is the highest level of education you have completed? (Please check one)
   □ Elementary School
   □ Middle School
   □ High School
   □ Associate Degree (2 Years of College)
   □ Bachelor’s Degree (4 Years of College)
   □ Master’s Degree
   □ Doctoral /Professional Degree
   □ Other: _____________

4. Did you have health insurance at the start of this class?
   □ Yes
   □ No

5. Did your children have health insurance at the start of this class? (Please check one)
   □ Yes
   □ No
   □ I don’t have children

6. Have you shared the information you learned with friends and/or family?
   □ Yes
   □ No
7. Would you recommend this class to someone else?
   □ Yes
   □ No

8. Have you or any family members done any of the following because of the information you learned in your class? (Please check ALL that apply):
   □ Seen a doctor
   □ Visited a free or low-cost clinic
   □ Enrolled in a health insurance plan
   □ Applied for Florida KidCare
   □ Applied for Medicare
   □ Applied for Medicaid
   □ Applied for WIC (Nutrition Program for Women, Infant, and Children)
   □ Applied for the Florida Discount Drug Card
   □ Changed eating habits
   □ Started exercising regularly
   □ Visited new health-related websites
   □ Other: ______________________

9. Has the health information you learned in this class helped you in your life?
   □ Yes
   □ No
   If yes, how? ______________________________________________________
   ____________________________________________________________

10. What is the most important thing you learned about in this class?

11. Is there anything that you would change about the program?