Exhibit 3

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, *et al.*, Plaintiffs, v. DONALD J. TRUMP, *in his official capacity as President of the United States, et al.*, Defendants.	20 Civ. 5770 (JMF) **DECLARATION OF ALLISON ARWARDY**

Pursuant to 28 U.S.C. § 1746(2), I, Allison Arwady, hereby declare as follows:

1. I am over the age of eighteen and have personal knowledge of all the facts stated herein.

2. My name is Allison Arwady, M.D., and I make this Declaration in connection with *State of New York, et al., v. Trump, et al.* . I was confirmed by the Chicago City Council as Commissioner of the Chicago Department of Public Health ("CDPH") in January 2020. I lead the City's public health response to the COVID-19 pandemic, ensuring through data analysis, testing, case investigation and contact tracing, quarantine/isolation, health care system support, and the dissemination of public guidance that the outbreak has remained well controlled. Under my leadership, CDPH has also been instrumental in enacting an expansion of services and strengthened policies for mental health, violence prevention, and environmental health. CDPH is now preparing to launch Healthy Chicago 2025, a four-year plan created with more than 200 partner organizations and residents to advance health equity by reducing the city's racial life expectancy gap.

3. As the chief executive of CDPH, my primary responsibility is to assure the health and wellbeing of Chicago's 2.7 million residents. My duties include managing the human, financial, and physical resources of CDPH to reduce health inequities while improving the health of the entire population. CDPH does this by establishing policies, developing systems, and implementing programs that meet community health needs.

4. To assure the health and wellbeing of Chicago residents—prioritizing the populations and neighborhoods of greatest need—CDPH relies on complete and accurate census data. Monitoring the health status of Chicago residents requires citywide and subpopulation

level data, such as the numbers of individuals by race/ethnicity, age, gender, socioeconomic status, and neighborhood of residence. Without accurate census data, CDPH will have difficulty assuring appropriate allocation of resources to the most appropriate populations and neighborhoods. We also will be unable to track progress or identify the best possible interventions to achieve our overarching goal of reducing the city's racial life expectancy gap.

5. The census data for Chicago is particularly important in 2020 as there have been unprecedented socio-demographic population shifts by race, ethnicity, and geography over this last decade. These changes include greater economic stratification, with many Latinos moving to different neighborhoods due to gentrification, African Americans leaving the city in record numbers, and the population of young, upper-income White residents on the rise. An incomplete count would strike at the core of our work as these underlying population numbers are how we calculate disease prevalence rates, measure racial and geographic disparities, and adjust rates for differences in population distribution by age. We use this data to monitor birth outcomes (e.g. teen birth), mortality (e.g. heart disease, diabetes, infectious disease), and morbidity (e.g., HIV, lead poisoning prevalence, opioid overdose rates, asthma ED visits, traffic crash injury, mental health hospitalizations).

6. Complete and accurate data is critical to CDPH's response to the COVID-19 pandemic. This data affects where we target our interventions including testing, communications, and policies to strengthen the local safety net and increase access to care. In the coming years, we will also use this data to inform how and where we provide vaccines to stop the virus from continuing to spread in Chicago.

7. CDPH uses decennial census data to weight our Healthy Chicago Survey and the Youth Risk Behavioral Survey data so that the survey sample accurately reflects the entire population. All estimates of behavior (e.g. smoking), health screening (e.g. mammograms), access to care (e.g. regular doctor visits), and percent of the population with certain health conditions (e.g. obesity, hypertension, diabetes) would be compromised by undercounts in Census 2020.

8. CDPH uses citywide and subpopulation disease and health behavior prevalence rates to:

    a. Determine disease and health behavior disparities for geographic, racial/ethnic, gender, and socioeconomic subpopulations;
    b. Inform where to provide services directly. For example, CDPH locates our clinical services (e.g., immunizations, STI, mental health) in high-need neighborhoods and focuses public awareness campaigns in communities with high rates of disease or disease promoting behaviors;

c. Allocate financial resources. CDPH defines and prioritizes high-risk populations and neighborhoods and requires applicants to describe their ability to provide services for these populations; and
d. Identify and respond to outbreaks of disease. CDPH uses population data to establish and monitor baseline patterns of disease so that aberrations in disease patterns can be detected and appropriate interventions can be implemented. As mentioned, this data is especially important to our response to the COVID-19 pandemic.

9. An incomplete count or inaccurate information on demographics from the census would undermine the interpretation of health data until at least the next decennial census (2030). Both today and a decade from now, lacking comparable data to previous years would make it much more difficult to track trends, particularly in sensitive areas where we as a city are at a critical juncture in making progress, like youth quality of life, HIV incidence, youth vaping, and, crucially, the chronic diseases that increase mortality rates from COVID-19.

10. Understanding and monitoring the relationship between health outcomes and the social determinants of health could be impacted by an incomplete or inaccurate census count. The decennial census is the gold-standard data source for measuring population and neighborhood characteristics related to factors such as poverty, employment, use of public benefits, housing, educational outcomes, and commuting behaviors, with an eye toward the needs of vulnerable populations like the disabled, elderly individuals living alone, and those who face impediments to mobility. The proposed change to census apportionment, and its resulting impact on census data counts could have a profound impact on interventions related to community development—and on emergency preparedness to deal with outbreaks and other urgent threats.

I declare under penalty of perjury that, to the best of my knowledge, the foregoing is true and correct. Executed on this 4th day of August, 2020

Allison Arwady, M.D.

Commissioner, Chicago Department of Public Health