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OMB#: 0925-0584
Exp. 08/31/2017

HCHS/SOL- Visit 2- Health Care Questionnaire

ID NUMBER:

FORM CODE: HCE
VERSION: 1, 11/20/2014

Contact Occasion

0 2

SEQ #

ADMINISTRATIVE INFORMATION

0a. Completion Date: / /

0b. Staff ID:

0c. Participant Gender: (1=Male, 2=Female)

0d. Age:

0e. Does the participant have diabetes? (0=No, 1=Yes)

Instructions: Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc for those questions that do not list these values as possible answer choices.

A. This first block of questions [Q1-8a] is about health care sought and received in the preceding 12 months.

Next I will ask questions about health care, the type of care you may have received recently and where you received care. Some of these questions refer to different medical care given to women and to men. Can I proceed to ask these questions?

1. In the past 12 months, did you receive any health care? (Select only one.)

No 0 GO TO QUESTION 5

Yes 1

Refused 8 GO TO QUESTION 5

Don't Know/ Not Sure 9 GO TO QUESTION 5

2. What was the reason for seeking health care? (Select all that apply.)

- | | No | Yes |
|---|----------------------------|----------------------------|
| a. Annual check-up and/or preventive care | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| b. Pregnancy-related care | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| c. Acute care (sudden illness not requiring going to the emergency room) | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| d. Injury or accident | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| e. Emergency care | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| f. Chronic or regular care of a disease (e.g. diabetes, hypertension, cancer, asthma) | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| g. Obtaining a prescription or filling prescriptions | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| h. Hospitalization | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| i. Other | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| i.1. (Specify: _____) | | |
| j. Refused | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| k. Don't know/Not Sure | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

ID NUMBER:									
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FORM CODE: HCE
VERSION: 1, 11/20/2014

Contact
Occasion

0	2
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SEQ #		
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3. In the past 12 months, where did you receive your medical care?
- | | All the time | Most of the time | Some of the time | None of the time |
|---|----------------------------|----------------------------|----------------------------|----------------------------|
| a. In the United States mainland | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| b. In Puerto Rico | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| c. In Mexico | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| d. In Canada | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| e. In another country not mentioned above | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| e.1. Specify: _____ | | | | |

4. In the past 12 months, where did you receive your dental care?
- | | All the time | Most of the time | Some of the time | None of the time |
|---|----------------------------|----------------------------|----------------------------|----------------------------|
| a. In the United States mainland | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| b. In Puerto Rico | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| c. In Mexico | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| d. In Canada | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| e. In another country not mentioned above | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| e.1. Specify: _____ | | | | |

5. In the past 12 months, was there a time when you needed health care, but could not get it? (Select only one.)

- No 0 GO TO QUESTION 9
 Yes 1
 Refused 8 GO TO QUESTION 9
 Don't Know/ Not Sure 9

6. In the past 12 months, were you unable to get any of the following due to financial reasons? (Select all that apply.)
- | | No | Yes |
|--|----------------------------|----------------------------|
| a. Prescription medications | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| b. To go to see a general health care professional | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| c. To go to see a specialist | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| d. Surgical procedure | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| e. Clinical procedure | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| f. Behavioral therapy, stress management/counseling/mental health services | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| g. Dental care | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| h. Eyeglasses | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| i. I had difficulty getting or affording other service(s) | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| i.1. Specify: _____ | | |
| j. Refused | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| k. Don't know/Not Sure | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

ID NUMBER:									
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0	2
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SEQ #		
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7. In the past 12 months, how many times did you go to an acute or urgent care center, or emergency room to get care for yourself?

Number of times If = 0, GO TO QUESTION 8

a. How many of these visits took place in the U.S. mainland? (Select only one.)

- All 1
- Most 2
- Some 3
- None 4

8. In the past 12 months, not counting times you went to an emergency room or urgent care facility, how many times did you go to a doctor, nurse or other health professional to get care for yourself for any reason?

Number of times If = 0, GO TO QUESTION 9

a. How many of these visits took place in the U.S. mainland? (Select only one.)

- All 1
- Most 2
- Some 3
- None 4

B. This second block of questions [Q9-12] is about routine medical care.

9. Do you have one person you think of as your personal doctor or health care provider? (Select only one.)

- No 0
- Yes, only one 1
- More than one 2
- Refused 8
- Don't know/Not Sure 9

10. What kind of place do you USUALLY go to when you need routine or preventive care, such as a physical examination or check-up? (Select all that apply.)

- | | No | Yes |
|--|----------------------------|----------------------------|
| a. Doesn't get preventive or routine care anywhere | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| b. Doesn't go to one place most often | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| c. Hospital emergency room | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

[If "Yes" to 10.a., 10.b., or 10.c., then GO TO QUESTION 12]

ID NUMBER:								
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0	2
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SEQ #		
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11. **[Interviewer: If "No" to 10.a., 10.b., and 10.c., then select all that apply from the choices below:]**

- | | No | Yes |
|-----------------------------------|----------------------------|----------------------------|
| a. Clinic or health center | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| b. Doctor's office or HMO | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| c. Hospital outpatient department | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| d. Some other place | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

11.d.1. Specify: _____

[GO TO QUESTION 13]

- | | No | Yes |
|---|----------------------------|----------------------------|
| 12. Why don't you have a usual source of medical care? (Select all that apply.) | | |
| a. Doesn't need a doctor/Haven't had any problems | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| b. Doesn't like/trust/believe in doctors | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| c. Doesn't know where to go | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| d. Previous doctor is not available/moved | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| e. Too expensive/no insurance/cost | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| f. Speak a different language | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| g. No care available/Care too far away, not convenient | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| h. Put it off/Didn't get around to it | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| i. Other | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| i.1. Specify _____ | | |
| j. Refused | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| k. Don't know/Not Sure | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

C. This third block of questions [Q13-30] is about utilization of screening and preventive services, and chronic care. [Some of the questions will be asked to all participants, whereas others will be asked to participants of specific age, gender or who have specific chronic diseases.]

13. **[All participants]** About how long has it been since you had a routine check-up by a doctor or other health professional? (Select only one.)

- Within past year [anytime less than 12 months ago] 1
- Within past 2 years [1 year but less than 2 years ago] 2
- Within past 3 years [2 years but less than 3 years ago] 3
- Within past 5 years [3 years but less than 5 years ago] 4
- 5 or more years ago 5
- Never 6
- Refused 8
- Don't know/Not Sure 9

ID NUMBER:									
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FORM CODE: HCE
VERSION: 1, 11/20/2014

Contact
Occasion

0	2
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SEQ #

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14. **[All participants]** About how long has it been since you had a flu vaccination (shot or nasal spray)?
(Select only one.)

- Within past year [anytime less than 12 months ago] 1
- Within past 2 years [1 year but less than 2 years ago] 2
- Within past 3 years [2 years but less than 3 years ago] 3
- Within past 5 years [3 years but less than 5 years ago] 4
- 5 or more years ago 5
- Never 6
- Refused 8
- Don't know/Not Sure 9

15. **[All participants]** A pneumonia shot or pneumococcal vaccine (Pneumovax®, Pnu-Imune®) is usually given only once or twice in a person's lifetime and is different from the flu shot. Have you ever had a pneumonia shot? (Select only one.)

- No 0
- Yes 1
- Refused 8
- Don't Know/ Not Sure 9

16. **[All participants]** About how long has it been since you received the tetanus vaccine for adults (booster)?
(Select only one.)

- Within past year [anytime less than 12 months ago] 1
- Within past 2 years [1 year but less than 2 years ago] 2
- Within past 3 years [2 years but less than 3 years ago] 3
- Within past 5 years [3 years but less than 5 years ago] 4
- 5 or more years ago 5
- Never 6 GO TO QUESTION 17
- Refused 8 GO TO QUESTION 17
- Don't know/Not Sure 9 GO TO QUESTION 17

a. If you have received the tetanus vaccine, was that tetanus vaccine combined with the pertussis or whooping cough vaccine? (Select only one.)

- Yes, received the tetanus vaccine combined with the pertussis or whooping cough vaccine. 1
- Received the tetanus vaccine, but it was not combined with the pertussis vaccine. 2
- Received the tetanus vaccine, but do not know what type. 3

ID NUMBER:									
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FORM CODE: HCE
VERSION: 1, 11/20/2014

Contact
Occasion

0	2
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SEQ #		
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17. **[All participants]** About how long has it been since you had your vision checked (ability to see) by a doctor or an optometrist? (Select only one.)

- Not medically indicated 0
- Within past year [anytime less than 12 months ago] 1
- Within past 2 years [1 year but less than 2 years ago] 2
- Within past 3 years [2 years but less than 3 years ago] 3
- Within past 5 years [3 years but less than 5 years ago] 4
- 5 or more years ago 5
- Never 6
- Refused 8
- Don't know/Not Sure 9

18. **[All participants]** Has a doctor or other health professional EVER told you to take a low-dose aspirin every day or every other day to prevent or control heart disease? (Select only one.)

- No 0 GO TO QUESTION 19
- Yes 1
- Refused 8 GO TO QUESTION 19
- Don't know/Not Sure 9 GO TO QUESTION 19

a. Are you NOW following this advice?

- No 0
- Yes 1
- No, because I do not tolerate aspirin or have experienced an adverse reaction to it 2
- Refused 8
- Don't know/Not Sure 9

19. **[All Participants]** Have you EVER had a test to detect colorectal cancer (cancer of the colon, large intestine and rectum)? (Select only one.)

- No 0 GO TO QUESTION 20
- Yes 1
- Refused 8 GO TO QUESTION 20
- Don't know/Not Sure 9

a. If "yes" or "not sure", what test?

a.1. Kit to detect occult blood or DNA in your stool?

- No 0 GO TO QUESTION 19.a.2.
- Yes 1

a.1.a. Date of test: / / (approximate date or year)

ID NUMBER:									
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FORM CODE: HCE
VERSION: 1, 11/20/2014

Contact
Occasion

0	2
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SEQ #		
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a.2. Sigmoidoscopy?

No 0 GO TO QUESTION 19.a.3.

Yes 1

a.2.a. Date of test:

// (approximate date or year)

a.3. Colonoscopy?

No 0 GO TO QUESTION 20

Yes 1

a.3.a. Date of test: // (approximate date or year)

20. **All participants** Have you EVER had a human papilloma virus (HPV) vaccination? (Select only one.)

No 0 Women GO TO QUESTION 21
Men with diabetes GO TO QUESTION 24
Men without diabetes GO TO QUESTION 31

Yes 1

Not recommended by a doctor or health professional 2 Women GO TO QUESTION 21
Men with diabetes GO TO QUESTION 24
Men without diabetes GO TO QUESTION 31

Refused 8 Women GO TO QUESTION 21
Men with diabetes GO TO QUESTION 24
Men without diabetes GO TO QUESTION 31

Don't know/Not Sure 9 Women GO TO QUESTION 21
Men with diabetes GO TO QUESTION 24
Men without diabetes GO TO QUESTION 31

a. How many HPV shots did you receive?

Number of shots

Men with diabetes GO TO QUESTION 24
Men without diabetes GO TO QUESTION 31

21. **Women only** How long has it been since you had your last mammogram? (Select only one.)

Not medically indicated 0

Within past year [anytime less than 12 months ago] 1

Within past 2 years [1 year but less than 2 years ago] 2

Within past 3 years [2 years but less than 3 years ago] 3

Within past 5 years [3 years but less than 5 years ago] 4

5 or more years ago 5

Never 6

Refused 8

Don't know/Not Sure 9

ID NUMBER:									
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FORM CODE: HCE
VERSION: 1, 11/20/2014

Contact Occasion	0	2	SEQ #		
------------------	---	---	-------	--	--

22. **Women only** How long has it been since you had your last Pap test (test of cancer of the cervix)? (Select only one.)

- Not medically indicated 0
- Within past year [anytime less than 12 months ago] 1
- Within past 2 years [1 year but less than 2 years ago] 2
- Within past 3 years [2 years but less than 3 years ago] 3
- Within past 5 years [3 years but less than 5 years ago] 4
- 5 or more years ago 5
- Never 6
- Refused 8
- Don't know/Not Sure 9

23. **Women aged 65 years and older** Have you EVER had a test to detect osteoporosis (low density of the bones)? (Select only one.)

- No 0 Women with diabetes GO TO QUESTION 24
Women without diabetes GO TO QUESTION 31
- Yes 1 Women with diabetes GO TO QUESTION 24
Women without diabetes GO TO QUESTION 31
- Refused 8 Women with diabetes GO TO QUESTION 24
Women without diabetes GO TO QUESTION 31
- Don't know/Not Sure 9 Women with diabetes GO TO QUESTION 24
Women without diabetes GO TO QUESTION 31

24. **Participants with diabetes** About how long has it been since you had your eyes checked, in which your pupils were dilated, to determine whether diabetes has affected your retina (the inner layer inside your eyes)? (Select only one.)

- Not medically indicated 0
- Within past year [anytime less than 12 months ago] 1
- Within past 2 years [1 year but less than 2 years ago] 2
- Within past 3 years [2 years but less than 3 years ago] 3
- Within past 5 years [3 years but less than 5 years ago] 4
- 5 or more years ago 5
- Never 6
- Refused 8
- Don't know/Not Sure 9

ID NUMBER:									
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FORM CODE: HCE
VERSION: 1, 11/20/2014

Contact
Occasion

0	2
---	---

SEQ #		
-------	--	--

25. **[Participants with diabetes]** About how long has it been since you had a urine test done to determine whether diabetes has affected your kidneys? (Select only one.)

- Not medically indicated (or dialysis) 0
- Within past year [anytime less than 12 months ago] 1
- Within past 2 years [1 year but less than 2 years ago] 2
- Within past 3 years [2 years but less than 3 years ago] 3
- Within past 5 years [3 years but less than 5 years ago] 4
- 5 or more years ago 5
- Never 6
- Refused 8
- Don't know/Not Sure 9

26. **[Participants with diabetes]** In the past 12 months, have you, a family member, or a friend checked your feet for any sores or lesions? (Select only one.)

- Never 3 GO TO QUESTION 27
- Yes 1
- Has no feet 2 GO TO QUESTION 28
- Refused 8 GO TO QUESTION 27
- Don't know/Not Sure 9 GO TO QUESTION 27

a. If yes, how often have you checked your feet for any sores or lesions? Include times when checked by the participant, a family member, or friend, but do NOT include times when checked by a health professional. (Select only one.)

- Every day 1
- Three or four times per week 2
- Once a week 3
- Once or twice a month 4

27. **[Participants with diabetes]** In the past 12 months, did a doctor, nurse, or other health professional check your feet for sores or lesions? (Select only one.)

- Never 3 GO TO QUESTION 28
- Yes 1
- Refused 8 GO TO QUESTION 28
- Don't know/Not Sure 9 GO TO QUESTION 28

a. If yes, about how many times? Number of times

ID NUMBER:									
------------	--	--	--	--	--	--	--	--	--

FORM CODE: HCE
VERSION: 1, 11/20/2014

Contact
Occasion

0	2
---	---

SEQ #		
-------	--	--

28. **[Participants with diabetes]** Do you, a family member, or friend check your blood glucose (sugar)? (Select only one).

Never 3 GO TO QUESTION 29

Yes 1

Refused 8 GO TO QUESTION 29

Don't know/Not Sure 9 GO TO QUESTION 29

a. If yes, how often have you checked your blood glucose (sugar)? Include the times when checked by the participant, family member, or friend, but do NOT include times when checked by a health professional. (Select answer according to the protocol.)

a1. times per day GO TO QUESTION 28.a.2

a2. number of days per week If =00, GO TO QUESTION 28.a.3
If >00, GO TO QUESTION 29

a3. number of days per month GO TO QUESTION 29

29. **[Participants with diabetes]** A test for hemoglobin A1c measures the average blood glucose (sugar in the blood) level in the previous 3 months. In the past 12 months, has a physician, a nurse or other health professional checked your hemoglobin A1c? (Select only one.)

No 0 GO TO QUESTION 31

Yes 1

Had never heard of the hemoglobin

A1c test 3 GO TO QUESTION 31

Refused 8 GO TO QUESTION 31

Don't know/Not Sure 9 GO TO QUESTION 31

a. If yes, how many times? GO TO QUESTION 30

30. **[Participants with diabetes]** Do you know your hemoglobin A1c level? (Select only one)

No 0

Yes 1

Refused 8

Don't know/Not Sure 9

ID NUMBER:									
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FORM CODE: HCE
VERSION: 1, 11/20/2014

Contact
Occasion

0	2
---	---

SEQ #		
-------	--	--

D. This next block of questions [Q31-38] is about health insurance.

31. Do you have health insurance or health care coverage? (Select only one.)

- No 0 GO TO QUESTION 36
Yes 1
Refused 8 GO TO QUESTION 36
Don't know/Not Sure 9

32. Are you CURRENTLY covered by any of the following types of health insurance or health coverage plans? (Mark "Yes" or "No" for EACH type of coverage in items a – h.)

- | | No | Yes |
|---|----------------------------|----------------------------|
| a. Insurance through your current or former employer or union (or employer of your spouse, partner, or another family member) | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| b. Insurance purchased directly from an insurance company (by you or another family member) | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| c. Medicare, for people 65 and older, or people with certain disabilities | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| d. Medicaid, Medi-Cal, or any kind of government-assistance plan for those with low income or a disability | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| e. Veterans Administration (VA) (including those who have ever used or enrolled for VA health care) | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| f. TRICARE, CHAMPUS or other military health care plan | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| g. Indian Health Service | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| h. Any other type of health insurance or health coverage plan | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| h.1. Specify _____ | | |
| i. Refused | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| j. Don't know/Not Sure | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

33. The health reform law (commonly known as the Affordable Care Act or "Obamacare") establishes new federal and state marketplaces (also called exchanges) where the uninsured and workers in small businesses can go to purchase insurance. Have you acquired coverage through one of these new marketplaces (Covered California; nystateofhealth.ny.org; HealthCare.gov; CiudadodeSalud.gov)? (Select only one.)

- No 0
Yes 1
Refused 8
Don't know/Not Sure 9

34. In the past 12 months, have you received coverage for medical expenses through Emergency Medicaid? (Select only one.)

- No 0
Yes 1
Refused 8
Don't know/Not Sure 9

ID NUMBER:									
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FORM CODE: HCE
VERSION: 1, 11/20/2014

Contact
Occasion

0	2
---	---

SEQ #		
-------	--	--

35. A catastrophic health insurance plan covers 3 annual primary care visits, and only provides coverage for medical expenses after the individual pays thousands of dollars (for example, the first \$6,000 or more in medical expenses). In the past 12 months, have you purchased a catastrophic health insurance plan? [Note to the interviewers: Catastrophic health plans cover persons younger than age 30 years.] (Select only one.)

- No 0 GO TO QUESTION 39
Yes 1 GO TO QUESTION 39
Refused 8 GO TO QUESTION 39
Don't know/Not Sure 9 GO TO QUESTION 39

36. About how long has it been since you last had health insurance coverage? (Select only one.)

- 6 months or less 1
More than 6 months, but not more than 1 year 2
More than 1 year, but not more than 3 years 3
More than 3 years 4
Never had insurance 5
Refused 8
Don't know/Not Sure 9

37. What are the main reasons you do not currently have health insurance?
Check all that apply.

No Yes

- | | | |
|---|----------------------------|----------------------------|
| a. It is too expensive/ the cost is too high | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| b. I am not eligible for coverage through my employer | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| c. My employer (or the employer of my spouse, partner, or another relative) does not offer insurance coverage | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| d. I was denied insurance coverage due to a previous medical condition | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| e. I am not eligible for Medicaid/Medi-Cal or have recently lost my Medicaid/Medi-Cal coverage | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| f. I lost the ability to purchase health insurance coverage through my spouse, partner or other relative | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| g. I am not eligible for premium tax credits or other tax credits | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| h. I am not eligible due to my citizenship status | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| i. I don't need insurance | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| j. I don't know how to get insurance | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| k. Other k.1. Specify: _____ | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| l. Refused | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| m. Don't know/Not Sure | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> |

ID NUMBER:									
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FORM CODE: HCE
VERSION: 1, 11/20/2014

Contact Occasion	0	2	SEQ #		
------------------	---	---	-------	--	--

38. In the past 12 months, have you received coverage for medical expenses through Emergency Medicaid? (Select only one).

- No 0
- Yes 1
- Refused 8
- Don't know/Not Sure 9

E. The following block of questions [Q39-41] is about place of birth and citizenship status.

In this last section of the questionnaire I will ask you some questions about your place of birth and citizenship status. Some people find these questions to be sensitive or private in nature. Some persons do not feel comfortable answering them. You may choose to answer some of them, or not answer them at all. We, the SOL team, respect your decision. If you choose to NOT answer some or any of the questions, we want to assure you that your participation in the study or any referrals that have been scheduled for you WILL NOT be affected. We will keep your answers confidential. We will block your answers so no one outside of the study will be able to see them.

These questions will be asked to all participants.

39. Where were you born? (Select only one.)

- In the U.S. 1
- Specify State or territory: _____
- Outside of the U.S. 2
- Specify country _____
- Specify province or state _____
- Specify city or town _____

40. Are you a U.S. citizen? (Select only one).

- No, not a U.S. citizen 0
- Yes, was born in the United States 1 End Questionnaire
- Yes, was born in Puerto Rico, Guam, the U.S. Virgin Islands, or Northern Marianas 2 End Questionnaire
- Yes, was born abroad to a U.S. citizen parent or parents 3 End Questionnaire
- Yes, is a citizen by naturalization 4 End Questionnaire
- Specify year: _____
- Refused 8 End Questionnaire
- Don't know/Not Sure 9 End Questionnaire

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FORM CODE: HCE
VERSION: 1, 11/20/2014

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41. If the previous answer is "No", which of the following situations describes you best? (Select only one)

Permanent resident card holder ("Green card" holder) 1

Have applied for a "Green card" 2

Holder of another type of visa 3

Specify: _____

None of the above 4

Refused 8

Don't know/Not Sure 9