26010249

National Survey of Children's Health

A study by the U.S. Department of Health and Human Services to better understand the health issues faced by children in the United States today.

The U.S. Census Bureau is required by law to protect your information and is not permitted to publicly release your responses in a way that could identify you or your household. The U.S. Census Bureau is conducting the National Survey of Children's Health on the behalf of the Department of Health and Human Services (HHS) under Title 13, United States Code, Section 8(b), which allows the Census Bureau to conduct surveys on behalf of other agencies. Title 42 U.S.C. Section 701(a)(2) allows HHS to collect information for the purpose of understanding the health and well-being of children in the United States. Federal law protects your privacy and keeps your answers confidential under 13 U.S.C. Section 9. Per the Federal Cybersecurity Enhancement Act of 2015, your data are protected from cybersecurity risks through screening of the systems that transmit your data.

Any information you provide will be shared for the work-related purposes identified above and as permitted under the Privacy Act of 1974 (5 U.S.C. Section 552a) and SORN COMMERCE/CENSUS-3, Demographic Survey Collection (Census Bureau Sampling Frame).

Participation in this survey is voluntary and there are no penalties for refusing to answer questions. However, your cooperation in obtaining this much needed information is extremely important in order to ensure complete and accurate results.

NSCH-T1
(09/23/2019) Draft 7

Start Here

Recently, you completed a survey that asked about the children usually living or staying at this address. Thank you for taking the time to complete that survey.

We now have some follow-up questions to ask about:

If the name listed above is not correct or does not correspond to a child living in this household, please call 1-800-845-8241 for assistance.

We have selected only one child per household in an effort to minimize the amount of time you will need to complete the follow-up questions.

The survey should be completed by a parent or adult caregiver who lives in this household and who is familiar with this child's health and health care.

Your participation is important. Thank you.

A. This Child's Health

A1 **In general, how would you describe this child's health (the one named above)?**

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

A2 **How would you describe the condition of this child's teeth?**

- ☐ This child does not have any teeth
- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

A3 **DURING THE PAST 12 MONTHS, has this child had FREQUENT or CHRONIC difficulty with any of the following?**

	Yes	No
a. Breathing or other respiratory problems (such as wheezing or shortness of breath)	☐	☐
b. Eating or swallowing because of a health condition	☐	☐
c. Digesting food, including stomach/intestinal problems, constipation, or diarrhea	☐	☐
d. Repeated or chronic physical pain, including headaches or other back or body pain	☐	☐
e. Using their hands	☐	☐
f. Coordination or moving around	☐	☐
g. Toothaches	☐	☐
h. Bleeding gums	☐	☐
i. Decayed teeth or cavities	☐	☐

A4 **Does this child have any of the following?**

	Yes	No
a. Deafness or problems with hearing	☐	☐
b. Blindness or problems with seeing, even when wearing glasses	☐	☐

Has a doctor or other health care provider EVER told you that this child has...

A5 **Allergies (including food, drug, insect, or other)?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A6 **Arthritis?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

Has a doctor or other health care provider EVER told you that this child has...

A7 **Asthma?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A8 **Cerebral Palsy?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A9 **Diabetes?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A10 **Epilepsy or Seizure Disorder?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A11 **Heart Condition?**

☐ Yes ☐ No

↳ **If yes, was this child born with the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A12 **Frequent or severe headaches, including migraine?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

Has a doctor or other health care provider EVER told you that this child has...

A13 **Tourette Syndrome?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A14 **Anxiety Problems?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A15 **Depression?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A16 **Down Syndrome?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A17 **Blood Disorders (such as Sickle Cell Disease, Thalassemia, or Hemophilia)?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

Was this condition identified through a blood test done shortly after birth? *These tests are sometimes called newborn screening.*

☐ Yes ☐ No

↳ **If yes, was this child diagnosed with:**

Sickle Cell Disease? ☐ Yes ☐ No

Thalassemia? ☐ Yes ☐ No

Hemophilia? ☐ Yes ☐ No

Other Blood Disorders? ☐ Yes ☐ No

Has a doctor or other health care provider EVER told you that this child has...

A18 **Cystic Fibrosis?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

Was this condition identified through a blood test done shortly after birth? *These tests are sometimes called newborn screening.*

☐ Yes ☐ No

A19 **Other genetic or inherited condition?**

☐ Yes ☐ No

↳ **If yes, specify:**

↳ **Is it:**

☐ Mild ☐ Moderate ☐ Severe

Was this condition identified through a blood test done shortly after birth? *These tests are sometimes called newborn screening.*

☐ Yes ☐ No

Has a doctor, other health care provider, or educator EVER told you that this child has...
Examples of educators are teachers and school nurses.

A20 **Behavioral or Conduct Problems?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A21 **Developmental Delay?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

Has a doctor, other health care provider, or educator EVER told you that this child has...
Examples of educators are teachers and school nurses.

A22 **Intellectual Disability (formerly known as Mental Retardation)?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the disability?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A23 **Speech or other language disorder?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A24 **Learning Disability?**

☐ Yes ☐ No

↳ **If yes, does this child CURRENTLY have the disability?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A25 **Has a doctor or other health care provider EVER told you that this child has Autism or Autism Spectrum Disorder (ASD)?** *Include diagnoses of Asperger's Disorder or Pervasive Developmental Disorder (PDD).*

☐ Yes ☐ No → ***SKIP to question A30 on page 5***

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A26 **How old was this child when a doctor or other health care provider FIRST told you that they had Autism, ASD, Asperger's Disorder or PDD?**

☐☐ Age in years ☐ Don't know

A27 **What type of doctor or other health care provider was the FIRST to tell you that this child had Autism, ASD, Asperger's Disorder or PDD?** *Mark (X) ONE box.*

- ☐ Primary Care Provider
- ☐ Specialist
- ☐ School Psychologist/Counselor
- ☐ Other Psychologist (Non-School)
- ☐ Psychiatrist
- ☐ Other, specify:

- ☐ Don't know

A28 **Is this child CURRENTLY taking medication for Autism, ASD, Asperger's Disorder or PDD?**

☐ Yes ☐ No

A29 **At any time DURING THE PAST 12 MONTHS, did this child receive behavioral treatment for Autism, ASD, Asperger's Disorder or PDD, such as training or an intervention that you or this child received to help with their behavior?**

☐ Yes ☐ No

A30 **Has a doctor or other health care provider EVER told you that this child has Attention Deficit Disorder or Attention Deficit/Hyperactivity Disorder, that is, ADD or ADHD?**

☐ Yes ☐ No → ***SKIP to question*** **A33**

↳ **If yes, does this child CURRENTLY have the condition?**

☐ Yes ☐ No

↳ **If yes, is it:**

☐ Mild ☐ Moderate ☐ Severe

A31 **Is this child CURRENTLY taking medication for ADD or ADHD?**

☐ Yes ☐ No

A32 **At any time DURING THE PAST 12 MONTHS, did this child receive behavioral treatment for ADD or ADHD, such as training or an intervention that you or this child received to help with their behavior?**

☐ Yes ☐ No

A33 **Do you think this child has EVER had a concussion or brain injury?** *A concussion or brain injury is when a blow or jolt to the head causes problems such as headaches, dizziness, being dazed or confused, difficulty remembering or concentrating, vomiting, blurred vision, changes in mood or behavior, or being knocked out.*

☐ Yes ☐ No → ***SKIP to question*** **A34**

↳ **If yes, did you seek medical care from a doctor or other health care provider?**

☐ Yes ☐ No → ***SKIP to question*** **A34**

↳ **If yes, did a doctor or other health care provider tell you that your child had a concussion or brain injury?**

☐ Yes ☐ No

A34 **DURING THE PAST 12 MONTHS, how often have this child's health conditions or problems affected their ability to do things other children their age do?**

- ☐ This child does not have any health conditions → ***SKIP to question*** **B1** ***on page 6***
- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

A35 **To what extent do this child's health conditions or problems affect their ability to do things?**

- ☐ Very little
- ☐ Somewhat
- ☐ A great deal

B. This Child as an Infant

B1 **Was this child born more than 3 weeks before their due date?**

☐ Yes

☐ No

B2 **What month and year was this child born?**

Birth Month / 4-Digit Birth Year

☐☐ / 20☐☐

B3 **How much did they weigh when born?** *Answer in pounds and ounces OR kilograms and grams.* ***Your best estimate is fine.***

☐☐ pounds **AND** ☐☐ ounces

OR

☐☐ kilograms **AND** ☐☐☐ grams

B4 **What was the age of the mother when this child was born?** *Your best estimate is fine.*

☐☐ Age in years

B5 **Was this child EVER breastfed or fed breast milk?**

☐ Yes

☐ No → ***SKIP to question*** **B7**

B6 **If yes, how old was this child when they COMPLETELY stopped breastfeeding or being fed breast milk?**

☐☐ days

OR

☐ weeks

OR

☐☐ months

OR

☐ *Check this box if child is still breastfeeding*

B7 **How old was this child when they were FIRST fed formula?**

☐ *Check this box if child has never been fed formula*

OR

☐ At birth

OR

☐☐ days

OR

☐ weeks

OR

☐☐ months

B8 **How old was this child when they were FIRST fed anything other than breast milk or formula?** *Include juice, cow's milk, sugar water, baby food, or anything else that your child might have been given, even water.*

☐ *Check this box if child has never been fed anything other than breast milk or formula*

OR

☐ At birth

OR

☐☐ days

OR

☐ weeks

OR

☐☐ months

C. Health Care Services

C1 **DURING THE PAST 12 MONTHS, did this child see a doctor, nurse, or other health care professional for sick-child care, well-child check-ups, physical exams, hospitalizations or any other kind of medical care?**

- ☐ Yes
- ☐ No → ***SKIP to question C4***

C2 **If yes, DURING THE PAST 12 MONTHS, how many times did this child visit a doctor, nurse, or other health care professional to receive a PREVENTIVE check-up?** *A preventive check-up is when this child was not sick or injured, such as an annual or sports physical, or well-child visit.*

- ☐ 0 visits
- ☐ 1 visit
- ☐ 2 or more visits

C3 **Thinking about the LAST TIME you took this child for a PREVENTIVE check-up, about how long was the doctor or health care provider who examined this child in the room with you?** *Your best estimate is fine.*

- ☐ Less than 10 minutes
- ☐ 10-20 minutes
- ☐ More than 20 minutes

C4 **Are you concerned about this child's weight?**

- ☐ Yes, it's too high
- ☐ Yes, it's too low
- ☐ No, I am not concerned

C5 **Has a doctor or other health care provider ever told you that this child is overweight?**

- ☐ Yes
- ☐ No

C6 **DURING THE PAST 12 MONTHS, did this child's doctors or other health care providers ask if you have concerns about this child's learning, development, or behavior?**

- ☐ Yes
- ☐ No

C7 ***Answer the following question only if this child is at least 9 months old. Otherwise skip to question C8.***

DURING THE PAST 12 MONTHS, did a doctor or other health care provider have you or another caregiver fill out a questionnaire about observations or concerns you may have about this child's development, communication, or social behaviors? *Sometimes a child's doctor or other health care provider will ask a parent to do this at home or during a child's visit.*

- ☐ Yes ☐ No

→ **If yes,** and this child is 9-23 Months:
Did the questionnaire ask about your concerns or observations about: *Mark (X) ALL that apply.*

- ☐ How this child talks or makes speech sounds?
- ☐ How this child interacts with you and others?

→ **If yes,** and this child is 2-5 Years:
Did the questionnaire ask about your concerns or observations about: *Mark (X) ALL that apply.*

- ☐ Words and phrases this child uses and understands?
- ☐ How this child behaves and gets along with you and others?

C8 **Is there a place you or another caregiver USUALLY take this child when they are sick or you need advice about their health?**

- ☐ Yes
- ☐ No → ***SKIP to question C10 on page 8***

C9 **If yes, where does this child USUALLY go first?** *Mark (X) ONE box.*

- ☐ Doctor's Office
- ☐ Hospital Emergency Room
- ☐ Hospital Outpatient Department
- ☐ Clinic or Health Center
- ☐ Retail Store Clinic or "Minute Clinic"
- ☐ School (Nurse's Office, Athletic Trainer's Office)
- ☐ Some other place

C10 **Is there a place that this child USUALLY goes when they need routine preventive care, such as a physical examination or well-child check-up?**

- ☐ Yes
- ☐ No → ***SKIP to question*** **C12**

C11 **If yes, is this the same place this child goes when they are sick?**

- ☐ Yes
- ☐ No

C12 **DURING THE PAST 12 MONTHS, has this child had their vision tested, such as with pictures, shapes, or letters?**

- ☐ Yes
- ☐ No → ***SKIP to question*** **C14**

C13 **If yes, where was this child's vision tested?** *Mark (X) ALL that apply.*

- ☐ Eye doctor or eye specialist (ophthalmologist, optometrist) office
- ☐ Pediatrician or other general doctor's office
- ☐ Clinic or health center
- ☐ School
- ☐ Other, specify:

C14 **DURING THE PAST 12 MONTHS, did this child see a dentist or other health care provider for any kind of dental or oral health care?**

- ☐ Yes, saw a dentist or other oral health care provider
- ☐ Yes, saw another kind of health care provider
- ☐ No → ***SKIP to question*** **C17**

C15 **If yes, DURING THE PAST 12 MONTHS, did this child see a dentist or other health care provider for PREVENTIVE dental care, such as check-ups, dental cleanings, dental sealants, or fluoride treatments?**

- ☐ No preventive visits in the past 12 months → ***SKIP to question*** **C17**
- ☐ Yes, 1 visit
- ☐ Yes, 2 or more visits

C16 **If yes, DURING THE PAST 12 MONTHS, what PREVENTIVE dental service(s) did this child receive?** *Mark (X) ALL that apply.*

- ☐ Check-up
- ☐ Cleaning
- ☐ Instruction on tooth brushing and oral health care
- ☐ X-Rays
- ☐ Fluoride treatment
- ☐ Sealant (plastic coatings on back teeth)
- ☐ Don't know

C17 **DURING THE PAST 12 MONTHS, has this child received any treatment or counseling from a mental health professional?** *Mental health professionals include psychiatrists, psychologists, psychiatric nurses, and clinical social workers.*

- ☐ Yes
- ☐ No, but this child needed to see a mental health professional
- ☐ No, this child did not need to see a mental health professional → ***SKIP to question*** **C19**

C18 **How difficult was it to get the mental health treatment or counseling that this child needed?**

- ☐ Not difficult
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ It was not possible to obtain care

C19 **DURING THE PAST 12 MONTHS, has this child taken any medication because of difficulties with their emotions, concentration, or behavior?**

- ☐ Yes
- ☐ No

C20 **DURING THE PAST 12 MONTHS, did this child see a specialist other than a mental health professional?** *Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care.*

- ☐ Yes
- ☐ No, but this child needed to see a specialist
- ☐ No, this child did not need to see a specialist → ***SKIP to question*** **C22** ***on page 9***

C21 **How difficult was it to get the specialist care that this child needed?**

- ☐ Not difficult
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ It was not possible to obtain care

C22 **DURING THE PAST 12 MONTHS, did this child use any type of alternative health care or treatment?** *Alternative health care can include acupuncture, chiropractic care, relaxation therapies, herbal supplements, and others. Some therapies involve seeing a health care provider, while others can be done on your own.*

- ☐ Yes
- ☐ No

C23 **DURING THE PAST 12 MONTHS, was there any time when this child needed health care but it was not received?** *By health care, we mean medical care as well as other kinds of care like dental care, vision care, and mental health services.*

- ☐ Yes
- ☐ No → ***SKIP to question*** **C26**

C24 **If yes, which types of care were not received?** *Mark (X) ALL that apply.*

- ☐ Medical Care
- ☐ Dental Care
- ☐ Vision Care
- ☐ Hearing Care
- ☐ Mental Health Services
- ☐ Other, specify:

C25 **Did any of the following reasons contribute to this child not receiving needed health services?** *Mark (X) Yes or No for each item.*

	Yes	No
a. This child was not eligible for the services	☐	☐
b. The services this child needed were not available in your area	☐	☐
c. There were problems getting an appointment when this child needed one	☐	☐
d. There were problems with getting transportation or child care	☐	☐
e. The clinic or doctor's office wasn't open when this child needed care	☐	☐
f. There were issues related to cost	☐	☐

C26 **DURING THE PAST 12 MONTHS, how often were you frustrated in your efforts to get services for this child?**

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

C27 **DURING THE PAST 12 MONTHS, how many times did this child visit a hospital emergency room?**

- ☐ None
- ☐ 1 time
- ☐ 2 or more times

C28 **DURING THE PAST 12 MONTHS, was this child admitted to the hospital to stay for at least one night?**

- ☐ Yes
- ☐ No

C29 **Has this child EVER had a special education or early intervention plan?** *Children receiving these services often have an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP).*

- ☐ Yes
- ☐ No → ***SKIP to question*** **C32**

C30 **If yes, how old was this child at the time of the FIRST plan?**

☐☐ Years **AND** ☐☐ Months

C31 **Is this child CURRENTLY receiving services under one of these plans?**

- ☐ Yes
- ☐ No

C32 **Has this child EVER received special services to meet their developmental needs such as speech, occupational, or behavioral therapy?**

- ☐ Yes
- ☐ No → ***SKIP to question*** **D1** ***on page 10***

C33 **If yes, how old was this child when they began receiving these special services?**

☐☐ Years **AND** ☐☐ Months

C34 **Is this child CURRENTLY receiving these special services?**

- ☐ Yes
- ☐ No

D. Experience with This Child's Health Care Providers

D1 **Do you have one or more persons you think of as this child's personal doctor or nurse?** *A personal doctor or nurse is a health professional who knows this child well and is familiar with this child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician's assistant.*

- ☐ Yes, one person
- ☐ Yes, more than one person
- ☐ No

D2 **DURING THE PAST 12 MONTHS, did this child need a referral to see any doctors or receive any services?**

- ☐ Yes
- ☐ No → ***SKIP to question*** **D4**

D3 **How difficult was it to get referrals?**

- ☐ Not difficult
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ It was not possible to get a referral

D4 ***Answer the following questions only if this child had a health care visit IN THE PAST 12 MONTHS. Otherwise skip to question*** **E1** ***on page 11.***

DURING THE PAST 12 MONTHS, how often did this child's doctors or other health care providers...

	Always	Usually	Sometimes	Never
a. Spend enough time with this child?	☐	☐	☐	☐
b. Listen carefully to you?	☐	☐	☐	☐
c. Show sensitivity to your family's values and customs?	☐	☐	☐	☐
d. Provide the specific information you needed concerning this child?	☐	☐	☐	☐
e. Help you feel like a partner in this child's care?	☐	☐	☐	☐

D5 **DURING THE PAST 12 MONTHS, did this child need any decisions to be made regarding their health care, such as whether to get prescriptions, referrals, or procedures?**

- ☐ Yes
- ☐ No → ***SKIP to question*** **D7**

D6 **If yes, DURING THE PAST 12 MONTHS, how often did this child's doctors or other health care providers...**

	Always	Usually	Sometimes	Never
a. Discuss with you the range of options to consider for their health care or treatment?	☐	☐	☐	☐
b. Make it easy for you to raise concerns or disagree with recommendations for this child's health care?	☐	☐	☐	☐
c. Work with you to decide together which health care and treatment choices would be best for this child?	☐	☐	☐	☐

D7 **DURING THE PAST 12 MONTHS, did anyone help you arrange or coordinate this child's care among the different doctors or services that this child uses?**

- ☐ Yes
- ☐ No
- ☐ Did not see more than one health care provider in the PAST 12 MONTHS → ***SKIP to question*** **D11** ***on page 11***

D8 **DURING THE PAST 12 MONTHS, have you felt that you could have used extra help arranging or coordinating this child's care among the different health care providers or services?**

- ☐ Yes
- ☐ No → ***SKIP to question*** **D10**

D9 **If yes, DURING THE PAST 12 MONTHS, how often did you get as much help as you wanted with arranging or coordinating this child's health care?**

- ☐ Usually
- ☐ Sometimes
- ☐ Never

D10 **DURING THE PAST 12 MONTHS, how satisfied were you with the communication between this child's doctors and other health care providers?**

- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied

D11 **DURING THE PAST 12 MONTHS, did this child's health care provider communicate with the child's school, child care provider, or special education program?**

- ☐ Yes
- ☐ No ➔ ***SKIP to question*** **E1**
- ☐ Did not need health care provider to communicate with these providers ➔ ***SKIP to question*** **E1**

D12 **If yes, during this time, how satisfied were you with the health care provider's communication with the school, child care provider, or special education program?**

- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied

E. This Child's Health Insurance Coverage

E1 **DURING THE PAST 12 MONTHS, was this child EVER covered by ANY kind of health insurance or health coverage plan?**

- ☐ Yes, this child was covered all 12 months ➔ ***SKIP to question*** **E4**
- ☐ Yes, but this child had a gap in coverage
- ☐ No

E2 **Indicate whether any of the following is a reason this child was not covered by health insurance at any time DURING THE PAST 12 MONTHS:**

	Yes	No
a. Change in employer or employment status	☐	☐
b. Cancellation due to overdue premiums	☐	☐
c. Dropped coverage because it was unaffordable	☐	☐
d. Dropped coverage because benefits were inadequate	☐	☐
e. Dropped coverage because choice of health care providers was inadequate	☐	☐
f. Problems with application or renewal process	☐	☐
g. Other, specify:	☐	☐

E3 **Is this child CURRENTLY covered by ANY kind of health insurance or health coverage plan?**

- ☐ Yes
- ☐ No ➔ ***SKIP to question*** **F1** ***on page 12***

E4 **Is this child CURRENTLY covered by any of the following types of health insurance or health coverage plans?** *Mark (X) Yes or No for EACH item.*

	Yes	No
a. Insurance through a current or former employer or union	☐	☐
b. Insurance purchased directly from an insurance company	☐	☐
c. Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability	☐	☐
d. TRICARE or other military health care	☐	☐
e. Indian Health Service	☐	☐
f. Other, specify:	☐	☐

E5 **How often does this child's health insurance offer benefits or cover services that meet this child's needs?**

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Never

E6 **How often does this child's health insurance allow them to see the health care providers they need?**

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Never

E7 **Thinking specifically about this child's mental or behavioral health needs, how often does this child's health insurance offer benefits or cover services that meet these needs?**

- ☐ This child does not use mental or behavioral health services
- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Never

F. Providing for This Child's Health

F1 **Including co-pays and amounts reimbursed from Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA), how much money did you pay for this child's medical, health, dental, and vision care DURING THE PAST 12 MONTHS?** *Do not include health insurance premiums or costs that were or will be reimbursed by insurance or another source.*

- ☐ $0 (No medical or health-related expenses) ➔ ***SKIP to question*** **F4**
- ☐ $1-$249
- ☐ $250-$499
- ☐ $500-$999
- ☐ $1,000-$5,000
- ☐ More than $5,000

F2 **How often are these costs reasonable?**

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Never

F3 **DURING THE PAST 12 MONTHS, did your family have problems paying for any of this child's medical or health care bills?**

- ☐ Yes
- ☐ No

F4 **DURING THE PAST 12 MONTHS, have you or other family members...**

	Yes	No
a. Left a job or taken a leave of absence because of this child's health or health conditions?	☐	☐
b. Cut down on the hours you work because of this child's health or health conditions?	☐	☐
c. Avoided changing jobs because of concerns about maintaining health insurance for this child?	☐	☐

F5 **IN AN AVERAGE WEEK, how many hours do you or other family members spend providing health care at home for this child?** *Care might include changing bandages, or giving medication and therapies when needed.*

- ☐ This child does not need health care provided at home on a weekly basis
- ☐ Less than 1 hour per week
- ☐ 1-4 hours per week
- ☐ 5-10 hours per week
- ☐ 11 or more hours per week

F6 **IN AN AVERAGE WEEK, how many hours do you or other family members spend arranging or coordinating health or medical care for this child, such as making appointments or locating services?**

- ☐ This child does not need health care coordinated on a weekly basis
- ☐ Less than 1 hour per week
- ☐ 1-4 hours per week
- ☐ 5-10 hours per week
- ☐ 11 or more hours per week

G. This Child's Learning

Answer the following question only if this child is at least 1 year old. Otherwise skip to **H1** ***on page 15.***

G1 **Is this child able to do the following...**
Mark (X) Yes or No for each item.

	Yes	No
a. Say at least one word, such as "hi" or "dog"?	☐	☐
b. Use 2 words together, such as "car go"?	☐	☐
c. Use 3 words together in a sentence, such as, "Mommy come now."?	☐	☐
d. Ask questions like "who," "what," "when," "where"?	☐	☐
e. Ask questions like "why" and "how"?	☐	☐
f. Tell a story with a beginning, middle, and end?	☐	☐
g. Understand the meaning of the word "no"?	☐	☐
h. Follow a verbal direction without hand gestures, such as "Wash your hands."?	☐	☐
i. Point to things in a book when asked?	☐	☐
j. Follow 2-step directions, such as "Get your shoes and put them in the basket."?	☐	☐
k. Understand words such as "in," "on," and "under"?	☐	☐

G2 **Is this child 3 years old or older?**

- ☐ Yes
- ☐ No → ***SKIP to question H1 on page 15***

G3 **Has this child started school?** *Include any formal home schooling.*

- ☐ Yes, preschool
- ☐ Yes, kindergarten
- ☐ Yes, first grade
- ☐ No

G4 **Are you concerned about how this child is learning to do things for themselves?**

- ☐ No
- ☐ Yes, somewhat concerned
- ☐ Yes, very concerned

G5 **How confident are you that this child is ready to be in school?**

- ☐ Completely confident
- ☐ Mostly confident
- ☐ Somewhat confident
- ☐ Not at all confident

G6 **How often can this child recognize the beginning sound of a word?** *For example, can this child tell you that the word "ball" starts with the "buh" sound?*

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never

G7 **About how many letters of the alphabet can this child recognize?**

- ☐ All of them
- ☐ Most of them
- ☐ About half of them
- ☐ Some of them
- ☐ None of them

G8 **Can this child rhyme words?**

- ☐ Yes
- ☐ No

G9 **How often can this child explain things they have seen or done so that you get a very good idea what happened?**

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never

G10 **How often can this child write their first name, even if some of the letters aren't quite right or are backwards?**

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never

G11 **How high can this child count?**

- ☐ This child cannot count
- ☐ Up to five
- ☐ Up to ten
- ☐ Up to 20
- ☐ Up to 50
- ☐ Up to 100 or more

G12 **How often can this child identify basic shapes such as a triangle, circle, or square?**

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never

G13 **Can this child identify the colors red, yellow, blue, and green by name?**

- ☐ Yes, all of them
- ☐ Yes, some of them
- ☐ No, none of them

G14 **How often is this child easily distracted?**

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never

G15 **How often does this child keep working at something until they are finished?**

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never

G16 **When this child is paying attention, how often can they follow instructions to complete a simple task?**

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never

G17 **How does this child usually hold a pencil?**

- ☐ Uses fingers to hold the pencil
- ☐ Grips the pencil in their fist
- ☐ This child cannot hold a pencil

G18 **How often does this child play well with others?**

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never

G19 **How often does this child become angry or anxious when going from one activity to another?**

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never

G20 **How often does this child show concern when others are hurt or unhappy?**

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never

G21 **When excited or all wound up, how often can this child calm down quickly?**

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never

G22 **How often does this child lose control of their temper when things do not go their way?**

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never

G23 **Compared to other children their age, how much difficulty does this child have making or keeping friends?**

- ☐ No difficulty
- ☐ A little difficulty
- ☐ A lot of difficulty

G24 **Compared to other children their age, how often is this child able to sit still?**

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Sometimes
- ☐ Never

G25 **How often...**

	Always	Usually	Sometimes	Never
a. Is this child affectionate and tender with you?	☐	☐	☐	☐
b. Does this child bounce back quickly when things do not go their way?	☐	☐	☐	☐
c. Does this child show interest and curiosity in learning new things?	☐	☐	☐	☐
d. Does this child smile and laugh?	☐	☐	☐	☐

H. About You and This Child

H1 **Was this child born in the United States?**

- ☐ Yes → ***SKIP to question*** **H3**
- ☐ No

H2 **If no, how long has this child been living in the United States?**

☐☐ Years **AND** ☐☐ Months

H3 **How many times has this child moved to a new address since they were born?**

☐☐ Number of times

H4 **How often does this child go to bed at about the same time on weeknights?**

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

H5 **DURING THE PAST WEEK, how many hours of sleep did this child get during an average day (count both nighttime sleep and naps)?**

- ☐ Less than 7 hours
- ☐ 7 hours
- ☐ 8 hours
- ☐ 9 hours
- ☐ 10 hours
- ☐ 11 hours
- ☐ 12 or more hours

H6 ***Answer the next question only if this child is LESS THAN 12 MONTHS OLD. Otherwise, SKIP to question*** **H7** ***.***

In which position do you most often lay this baby down to sleep now? *Mark (X) ONE box.*

- ☐ On their side
- ☐ On their back
- ☐ On their stomach

H7 **ON MOST WEEKDAYS, about how much time did this child spend in front of a TV, computer, cellphone or other electronic device watching programs, playing games, accessing the internet or using social media?** *Do not include time spent doing schoolwork.*

- ☐ Less than 1 hour
- ☐ 1 hour
- ☐ 2 hours
- ☐ 3 hours
- ☐ 4 or more hours

H8 **DURING THE PAST WEEK, how many days did you or other family members read to this child?**

- ☐ 0 days
- ☐ 1-3 days
- ☐ 4-6 days
- ☐ Every day

H9 **DURING THE PAST WEEK, how many days did you or other family members tell stories or sing songs to this child?**

- ☐ 0 days
- ☐ 1-3 days
- ☐ 4-6 days
- ☐ Every day

H10 **How well do you think you are handling the day-to-day demands of raising children?**

- ☐ Very well
- ☐ Somewhat well
- ☐ Not very well
- ☐ Not well at all

H11 **DURING THE PAST MONTH, how often have you felt...**

	Never	Rarely	Sometimes	Usually	Always
a. That this child is much harder to care for than most children their age?	☐	☐	☐	☐	☐
b. That this child does things that really bother you a lot?	☐	☐	☐	☐	☐
c. Angry with this child?	☐	☐	☐	☐	☐

H12 **DURING THE PAST 12 MONTHS, was there someone that you could turn to for day-to-day emotional support with parenting or raising children?**

- ☐ Yes
- ☐ No → ***SKIP to question*** **H14**

H13 **If yes, did you receive emotional support from...**

	Yes	No
a. Spouse or domestic partner?	☐	☐
b. Other family member or close friend?	☐	☐
c. Health care provider?	☐	☐
d. Place of worship or religious leader?	☐	☐
e. Support or advocacy group related to specific health condition?	☐	☐
f. Peer support group?	☐	☐
g. Counselor or other mental health professional?	☐	☐
h. Other person, specify:	☐	☐

H14 **Does this child receive care for at least 10 hours per week from someone other than their parent or guardian?** *This could be a day care center, preschool, Head Start program, family child care home, nanny, au pair, babysitter or relative.*

- ☐ Yes
- ☐ No

H15 **DURING THE PAST 12 MONTHS, did you or anyone in the family have to quit a job, not take a job, or greatly change your job because of problems with child care for this child?**

- ☐ Yes
- ☐ No

I. About Your Family and Household

I1 **DURING THE PAST WEEK, on how many days did all the family members who live in the household eat a meal together?**

- ☐ 0 days
- ☐ 1-3 days
- ☐ 4-6 days
- ☐ Every day

I2 **Does anyone living in your household use cigarettes, cigars, or pipe tobacco?**

- ☐ Yes
- ☐ No → ***SKIP to question*** **I4**

I3 **If yes, does anyone smoke inside your home?**

- ☐ Yes
- ☐ No

I4 **DURING THE PAST 12 MONTHS, how often were pesticides used inside your residence to control for insects?** *If the frequency changed throughout the year, report the highest frequency.*

- ☐ More than once a week
- ☐ Once a week
- ☐ Once a month
- ☐ Once every 2-5 months
- ☐ Once every 6 months
- ☐ Once during the past 12 months
- ☐ Never
- ☐ Don't know

I5 **DURING THE PAST 12 MONTHS, other than in a shower or bathtub, have you seen any mold, mildew or other signs of water damage on walls or other surfaces inside your home?**

- ☐ Yes
- ☐ No

I6 **SINCE THIS CHILD WAS BORN, how often has it been very hard to cover the basics, like food or housing, on your family's income?**

- ☐ Never
- ☐ Rarely
- ☐ Somewhat often
- ☐ Very often

I7 **Which of these statements best describes your household's ability to afford the food you need DURING THE PAST 12 MONTHS?**

- ☐ We could always afford to eat good nutritious meals.
- ☐ We could always afford enough to eat but not always the kinds of food we should eat.
- ☐ Sometimes we could not afford enough to eat.
- ☐ Often we could not afford enough to eat.

I8 **At any time DURING THE PAST 12 MONTHS, even for one month, did anyone in your family receive...**

	Yes	No
a. Cash assistance from a government welfare program?	☐	☐
b. Food Stamps or Supplemental Nutrition Assistance Program (SNAP) benefits?	☐	☐
c. Free or reduced-cost breakfasts or lunches at school?	☐	☐
d. Benefits from the Woman, Infants, and Children (WIC) Program?	☐	☐

I9 **In your neighborhood, is/are there...**

	Yes	No
a. Sidewalks or walking paths?	☐	☐
b. A park or playground?	☐	☐
c. A recreation center, community center, or boys' and girls' club?	☐	☐
d. A library or bookmobile?	☐	☐
e. Litter or garbage on the street or sidewalk?	☐	☐
f. Poorly kept or rundown housing?	☐	☐
g. Vandalism such as broken windows or graffiti?	☐	☐

I10 **To what extent do you agree with these statements about your neighborhood or community?**

	Definitely agree	Somewhat agree	Somewhat disagree	Definitely disagree
a. People in this neighborhood help each other out	☐	☐	☐	☐
b. We watch out for each other's children in this neighborhood	☐	☐	☐	☐
c. This child is safe in our neighborhood	☐	☐	☐	☐
d. When we encounter difficulties, we know where to go for help in our community	☐	☐	☐	☐

I11 **The next questions are about events that may have happened during this child's life. These things can happen in any family, but some people may feel uncomfortable with these questions. You may skip any questions you do not want to answer.**

To the best of your knowledge, has this child EVER experienced any of the following?

	Yes	No
a. Parent or guardian divorced or separated	☐	☐
b. Parent or guardian died	☐	☐
c. Parent or guardian served time in jail	☐	☐
d. Saw or heard parents or adults slap, hit, kick, punch one another in the home	☐	☐
e. Was a victim of violence or witnessed violence in their neighborhood	☐	☐
f. Lived with anyone who was mentally ill, suicidal, or severely depressed	☐	☐
g. Lived with anyone who had a problem with alcohol or drugs	☐	☐
h. Treated or judged unfairly because of their race or ethnic group	☐	☐

I12 **When your family faces problems, how often are you likely to do each of the following?**

	All of the time	Most of the time	Some of the time	None of the time
a. Talk together about what to do	☐	☐	☐	☐
b. Work together to solve our problems	☐	☐	☐	☐
c. Know we have strengths to draw on	☐	☐	☐	☐
d. Stay hopeful even in difficult times	☐	☐	☐	☐

J. Child's Caregivers

➔ **Complete the questions for UP TO TWO ADULTS in the household who are this child's primary caregivers.**

CAREGIVER 1 (You)

J1 **How are you related to this child?**

- ☐ Biological or Adoptive Parent
- ☐ Step-parent
- ☐ Grandparent
- ☐ Foster Parent
- ☐ Other: Relative
- ☐ Other: Non-Relative

J2 **What is your sex?**

- ☐ Male
- ☐ Female

J3 **What is your age?**

☐☐ Age in years

J4 **Where were you born?**

- ☐ In the United States ➔ ***SKIP to question*** **J6** ***on page 19***
- ☐ Outside of the United States

J5 **When did you come to live in the United States?**
Indicate the 4-digit year in which you came to live in the United States.

☐☐☐☐ 4-Digit Year

J6 **What is the highest grade or level of school you have completed?** *Mark (X) ONE box.*

- ☐ 8th grade or less
- ☐ 9th-12th grade; No diploma
- ☐ High School Graduate or GED Completed
- ☐ Completed a vocational, trade, or business school program
- ☐ Some College Credit, but no Degree
- ☐ Associate Degree (AA, AS)
- ☐ Bachelor's Degree (BA, BS, AB)
- ☐ Master's Degree (MA, MS, MSW, MBA)
- ☐ Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)

J7 **What is your marital status?**

- ☐ Married
- ☐ Not married, but living with a partner
- ☐ Never Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

J8 **In general, how is your physical health?**

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

J9 **In general, how is your mental or emotional health?**

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

J10 **Were you employed at least 50 out of the past 52 weeks?**

- ☐ Yes
- ☐ No

J11 **Have you ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard?** *Mark (X) ONE box.*

- ☐ Never served in the military ➔ ***SKIP to question*** **J13**
- ☐ Only on active duty for training in the Reserves or National Guard ➔ ***SKIP to question*** **J13**
- ☐ Now on active duty
- ☐ On active duty in the past, but not now

J12 **Were you deployed at any time during this child's life?**

- ☐ Yes
- ☐ No

J13 **Does this child have another primary adult caregiver who lives in this household?**

- ☐ Yes - *Complete Questions* **J14** - **J25**
- ☐ No - *SKIP to Question* **K1** *on page 20*

CAREGIVER 2

J14 **How is Caregiver 2 related to this child?**

- ☐ Biological or Adoptive Parent
- ☐ Step-parent
- ☐ Grandparent
- ☐ Foster Parent
- ☐ Other: Relative
- ☐ Other: Non-Relative

J15 **What is Caregiver 2's sex?**

- ☐ Male
- ☐ Female

J16 **What is Caregiver 2's age?**

☐☐ Age in years

J17 **Where was Caregiver 2 born?**

- ☐ In the United States ➔ ***SKIP to question*** **J19**
- ☐ Outside of the United States

J18 **When did Caregiver 2 come to live in the United States?** *Indicate the 4-digit year in which Caregiver 2 came to live in the United States.*

☐☐☐☐ 4-Digit Year

J19 **What is the highest grade or level of school Caregiver 2 has completed?** *Mark (X) ONE box.*

- ☐ 8th grade or less
- ☐ 9th-12th grade; No diploma
- ☐ High School Graduate or GED Completed
- ☐ Completed a vocational, trade, or business school program
- ☐ Some College Credit, but no Degree
- ☐ Associate Degree (AA, AS)
- ☐ Bachelor's Degree (BA, BS, AB)
- ☐ Master's Degree (MA, MS, MSW, MBA)
- ☐ Doctorate (PhD, EdD) or Professional Degree (MD, DDS, DVM, JD)

J20 **What is Caregiver 2's marital status?**

- ☐ Married
- ☐ Not married, but living with a partner
- ☐ Never Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

J21 **In general, how is Caregiver 2's physical health?**

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

J22 **In general, how is Caregiver 2's mental or emotional health?**

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

J23 **Was Caregiver 2 employed at least 50 out of the past 52 weeks?**

- ☐ Yes
- ☐ No

J24 **Has Caregiver 2 ever served on active duty in the U.S. Armed Forces, Reserves, or the National Guard?** *Mark (X) ONE box.*

- ☐ Never served in the military ➔ ***SKIP to question*** **K1**
- ☐ Only on active duty for training in the Reserves or National Guard ➔ ***SKIP to question*** **K1**
- ☐ Now on active duty
- ☐ On active duty in the past, but not now

J25 **Was Caregiver 2 deployed at any time during this child's life?**

- ☐ Yes
- ☐ No

K. Household Information

K1 **How many people are living or staying at this address?** *Include everyone who usually lives or stays at this address. Do NOT include anyone who is living somewhere else for more than two months, such as a college student living away or someone in the Armed Forces on deployment.*

☐☐ Number of people

K2 **How many of these people in your household are family members?** *Family is defined as anyone related to this child by blood, marriage, adoption, or through foster care.*

☐☐ Number of people

K3 **Income in 2019**

Mark (X) the "Yes" box for each type of income this child's family received, and give your best estimate of the TOTAL AMOUNT IN THE LAST CALENDAR YEAR. Mark (X) the "No" box to show types of income NOT received.

a. Wages, salary, commissions, bonuses, or tips for all jobs.

☐ Yes ➔ $, , .00

☐ No

TOTAL AMOUNT in the last calendar year

b. Self-employment income from own nonfarm businesses or farm business, including proprietorships and partnerships.

☐ Yes ➔ $, , .00 ☐ Loss

☐ No

TOTAL AMOUNT in the last calendar year

c. Interest, dividends, net rental income, royalty income, or income from estates and trusts.

☐ Yes ➔ $, , .00 ☐ Loss

☐ No

TOTAL AMOUNT in the last calendar year

d. Social security or railroad retirement; retirement, survivor, or disability pensions.

☐ Yes ➔ $, , .00

☐ No

TOTAL AMOUNT in the last calendar year

e. Supplemental security income (SSI); any public assistance or welfare payments from the state or local welfare office.

☐ Yes ➔ $, , .00

☐ No

TOTAL AMOUNT in the last calendar year

f. Any other sources of income received such as Veterans' (VA) payments, unemployment compensation, child support, alimony, gifts, prize winnings, etc.

☐ Yes ➔ $, , .00

☐ No

TOTAL AMOUNT in the last calendar year

K4 **The following question is about your 2019 income. Think about your total combined family income IN THE LAST CALENDAR YEAR for all members of the family. What is that amount before taxes?** *Include money from jobs, child support, social security, retirement income, unemployment payments, public assistance, and so forth. Also, include income from interest, dividends, net income from businesses, farm or rent, and any other money income received.*

$, , .00

TOTAL AMOUNT in the last calendar year

Mailing Instructions

Thank you for your participation.

On behalf of the U.S. Department of Health and Human Services, we would like to thank you for the time and effort you have spent sharing information about this child and your family.

Your answers are important to us and will help researchers, policymakers, and family advocates to better understand the health and health care needs of children in our diverse population.

Place the completed questionnaire in the postage-paid return envelope. If the envelope has been misplaced, mail the questionnaire to:

U.S. Census Bureau
ATTN: DCB 60-A
1201 E. 10th Street
Jeffersonville, IN 47132-0001

You may also call **1-800-845-8241** to request a replacement envelope.