Attachment 2a: SSP Client Screening Form

Form Approved
OMB No: 0920-1091
Exp. Date: 09/30/2021

RURAL EXPERIENCE AND ACCESS STUDY
Client Screening Form

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Date: ___________
Study identification number: _________
Screener Three Digit Initials: ________

Thank you for calling. My name is ________ and let me tell you a little about the study. I am part of a study team that wants to learn more about syringe service programs, HIV, Hepatitis B and C, injection drug use, and topics that will help us understand what services you need as well as what services you currently access. The study consists of a face-to-face interview that should take about an hour of your time in a place convenient to you. Before we schedule the interview, I have a few questions to see if you qualify for the study. You do not have to answer any questions you do not want to answer. You may stop at any time. Just let me know you no longer wish to answer any questions, and I will stop. If you do not qualify for this study, the information you have given me will be destroyed. If you are eligible and decide to participate, the answers that you give to these questions will be used in the study. Your answers will be identified by a study identification number, not your name. Do you have any questions before we proceed? Do I have your permission to proceed?

[SCREENER DIRECTIONS: PLEASE DO NOT READ THE OPTIONS IN ALL CAPS; THESE ARE IN CASE THE PARTICIPANT PROVIDES AN ANSWER NOT SPELLED OUT IN THE OPTIONS YOU ARE TO READ. ELIGIBILITY CRITERIA ARE: 18 YEARS AND OLDER, LIVE IN RURAL AREA, HAVE USED THE SSP'S SERVICES MORE THAN ONCE AND REPORT HAVING INJECTED DRUGS AT LEAST ONCE IN THE PAST 12 MONTHS]

1) How old are you?

2) Do you live in a rural, suburban or urban area?

3) What is your zip code?

4) Have you ever used the services at [name SSP]?

☐ Yes (ASK FOLLOW UP QUESTION)
☐ No (SKIP TO Q 5)

[IF YES] How many times?
☐ Only once
☐ More than once

5) When was the last time you injected drugs? _______ (ELIGIBITY: MUST BE IN THE PAST 12 MONTHS)

6) What sex were you assigned at birth, on your original birth certificate?

Male.. ☐ 1
Female.. ☐ 2
DON'T KNOW .... ☐ 3
REFUSED TO ANSWER .... ☐ 4

7) Do you currently describe yourself as male, female, or transgender?
Male .... ☐ 1
Female.. ☐ 2
Transgender... ☐ 3
NONE OF THESE .... ☐ 4
REFUSED TO ANSWER .... ☐ 5

8) Just to confirm, you were assigned {_FILL based on first question__} at birth and now describe yourself as {FILL based on 2nd question}. Is that correct?
☐ Yes
☐ No
☐ REFUSED TO ANSWER
☐ DON'T KNOW

9) Which of the following best represents how you think of yourself:

Gay (lesbian or gay).. ☐ 1
Straight, this is not gay (or lesbian or gay)........................ ☐ 2
Bisexual.. ☐ 3
SOMETHING ELSE .... ☐ 4
I DON'T KNOW THE ANSWER .... ☐ 5

10) Do you consider yourself to be Hispanic or Latino/a?
☐ Yes
☐ No
☐ REFUSED TO ANSWER

11) Which racial group, or groups, do you consider yourself to be? [READ CHOICES. CODE ALL THAT APPLY.]
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander

☐ White

12) In the past 12 months have you stayed on the street, in a shelter, or temporarily in someone's home because you had no regular place to live or stay?

Yes……………………….. ☐ 1 (ASK FOLLOW UP QUESTION)
No……………. ………… ☐ 2 (SKIP TO Q 12)
DON'T KNOW ………….. ☐ 3 (SKIP TO Q 12)
REFUSED TO ANSWER ………………… ☐ 4 (SKIP TO Q 12)

[IF YES] Do you consider yourself homeless?

Yes……………………….. ☐ 1
No……………………….. ☐ 2
DON'T KNOW ………….. ☐ 3
REFUSED TO ANSWER ………………… ☐ 4

13) Are you currently working at a job that pays money? (IF YES, PROBE FOR FULL- OR PART-TIME)

Yes, full-time………… ☐ 1
Yes, part-time………. ☐ 2
No ……………………….. ☐ 3
REFUSED TO ANSWER ………………. ☐ 4

14) Do you have health insurance?

Yes……………………….. ☐ 1 (ASK FOLLOW UP QUESTION)
No……………………….. ☐ 2 (SKIP TO Q 14)
DON'T KNOW ………….. ☐ 3 (SKIP TO Q 14)
REFUSED TO ANSWER ………………… ☐ 4 (SKIP TO Q 14)

[IF YES] Which of the follow health insurance plans do you have? [Check all that apply]

☐ Medicare
☐ Medicaid
☐ Private insurance, through your work, self-employment or retirement plan
☐ VA or military coverage
☐ OTHER: PLEASE SPECIFY: ___________
☐ DON'T KNOW
☐ REFUSED TO ANSWER

15) Do you currently have a health care provider/clinic (such as a doctor or a nurse) outside of [name of SSP]?

☐ Yes (ASK FOLLOW UP QUESION)
☐ No
☐ DON'T KNOW
REFUSED TO ANSWER

[IF YES] When was the last time you saw your health care provider?

☐ LESS THAN 1 YEAR AGO
☐ BETWEEN 1-2 YEARS AGO
☐ MORE THAN 2 YEARS AGO
☐ DON'T KNOW
☐ REFUSED TO ANSWER