CASE ID: ☐☐☐☐☐☐☐☐

Section A. Screener (PROGRAMMER: Add Timestamp)

A1. Are there any children 0-17 years old who usually live or stay at this household?

1 ☐ NO *[IF NO, STOP HERE. THIS IS THE END OF THE SURVEY]*
2 ☐ YES

A2. How many children 0-17 years old usually live or stay at this household?

☐☐ NUMBER OF CHILDREN LIVING OR STAYING AT THIS ADDRESS

A3. What is the primary language spoken in the household?

1 ☐ ENGLISH
2 ☐ SPANISH
3 ☐ ANOTHER LANGUAGE, *PLEASE SPECIFY:* ☐

Answer the remaining questions for each of the children 0-17 years old who usually live or stay at this address.

Start with the youngest child, who we will call "Child 1" and continue with the next youngest until you have answered the questions for all children who usually live or stay at this address.

A4. CHILD 1

What is this child's first name, initials, or nickname?

☐

A5. Is this child of Hispanic, Latino, or Spanish origin?

1 ☐ No, not of Hispanic, Latino, or Spanish origin
2 ☐ Yes, Mexican, Mexican American, Chicano
3 ☐ Yes, Puerto Rican
4 ☐ Yes, Cuban
5 ☐ Yes, another Hispanic, Latino, or Spanish origin, *please specify:*

☐

A6. What is this child's race or ethnicity? *SELECT ONE OR MORE.*

1 ☐ WHITE
2 ☐ BLACK OR AFRICAN AMERICAN
3 ☐ AMERICAN INDIAN OR ALASKA NATIVE, *PLEASE SPECIFY:*

4 ☐ ASIAN INDIAN
5 ☐ CHINESE
6 ☐ FILIPINO
7 ☐ JAPANESE
8 ☐ KOREAN
9 ☐ VIETNAMESE
10 ☐ OTHER ASIAN, *PLEASE SPECIFY:*

11 ☐ NATIVE HAWAIIAN
12 ☐ GUAMANIAN OR CHAMORRO
13 ☐ SAMOAN
14 ☐ TONGAN
15 ☐ SAIPANESE
16 ☐ MORTLOCKESE
17 ☐ KOSRAEN
18 ☐ CAROLINIAN
19 ☐ PALAUAN
20 ☐ POHNPEIAN
21 ☐ YAPESE
22 ☐ CHUUKESE
23 ☐ MARSHALLESE
24 ☐ OTHER PACIFIC ISLANDER, *PLEASE SPECIFY:*

A7. What is this child's sex?

1 ☐ MALE
2 ☐ FEMALE

A8. How old is this child? *If the child is less than one month old, round age in months to 1.*

☐☐ YEARS (OR) ☐☐ MONTHS
IF THIS CHILD IS YOUNGER THAN 4 YEARS OLD, GO TO A10.

A9. PUERTO RICO: How well does this child speak Spanish?

ALL OTHER JURISDICTIONS: How well does this child speak English?

1 ☐ Very well
2 ☐ Well
3 ☐ Not well
4 ☐ Not at all

A10. Does this child <u>currently</u> need or use medicine prescribed by a doctor, other than vitamins?

1 ☐ YES
2 ☐ NO *[GO TO A11]*

→ ***[IF YES]* is this child's need for prescription medicine because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A11]*

→ ***[IF YES]* is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A11. Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?

1 ☐ YES
2 ☐ NO *[GO TO A12]*

→ ***[IF YES]*** **is this child's need for medical care, mental health, or educational services because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A12]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A12. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

1 ☐ YES
2 ☐ NO *[GO TO A13]*

→ ***[IF YES]*** **is this child's limitation in abilities because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A13]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A13. Does this child need or get special therapy, such as physical, occupational, or speech therapy?

1 ☐ YES
2 ☐ NO *[GO TO A14]*

→ ***[IF YES]*** **is this because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A14]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A14. Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?

1 ☐ YES
2 ☐ NO *[GO TO A15]*

→ ***[IF YES]*** **has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

IF RESPONDENT HAS ANOTHER CHILD, CONTINUE WITH A15. ELSE CONTINUE WITH SECTION B.

A15. CHILD 2

What is this child's first name, initials, or nickname?

A16. Is this child of Hispanic, Latino, or Spanish origin?

1 ☐ No, not of Hispanic, Latino, or Spanish origin
2 ☐ Yes, Mexican, Mexican American, Chicano
3 ☐ Yes, Puerto Rican
4 ☐ Yes, Cuban
5 ☐ Yes, another Hispanic, Latino, or Spanish origin, *please specify:*

A17. What is this child's race or ethnicity? *SELECT ONE OR MORE.*

1 ☐ WHITE
2 ☐ BLACK OR AFRICAN AMERICAN
3 ☐ AMERICAN INDIAN OR ALASKA NATIVE, *PLEASE SPECIFY:*
4 ☐ ASIAN INDIAN
5 ☐ CHINESE
6 ☐ FILIPINO
7 ☐ JAPANESE
8 ☐ KOREAN
9 ☐ VIETNAMESE
10 ☐ OTHER ASIAN, *PLEASE SPECIFY:*
11 ☐ NATIVE HAWAIIAN
12 ☐ GUAMANIAN OR CHAMORRO
13 ☐ SAMOAN
14 ☐ TONGAN
15 ☐ SAIPANESE
16 ☐ MORTLOCKESE
17 ☐ KOSRAEN
18 ☐ CAROLINIAN
19 ☐ PALAUAN
20 ☐ POHNPEIAN
21 ☐ YAPESE
22 ☐ CHUUKESE
23 ☐ MARSHALLESE
24 ☐ OTHER PACIFIC ISLANDER, *PLEASE SPECIFY:*

A18. What is this child's sex?

1 ☐ MALE
2 ☐ FEMALE

A19. How old is this child? *If the child is less than one month old, round age in months to 1.*

☐☐ YEARS (OR) ☐☐ MONTHS

IF THIS CHILD IS YOUNGER THAN 4 YEARS OLD, GO TO A21.

A20. PUERTO RICO: How well does this child speak Spanish?

ALL OTHER JURISDICTIONS: How well does this child speak English?

1 ☐ Very well
2 ☐ Well
3 ☐ Not well
4 ☐ Not at all

A21. Does this child <u>currently</u> need or use medicine prescribed by a doctor, other than vitamins?

1 ☐ YES
2 ☐ NO *[GO TO A22]*

→ ***[IF YES]*** **is this child's need for prescription medicine because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A22]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A22. Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?

1 ☐ YES
2 ☐ NO *[GO TO A23]*

→ ***[IF YES]*** **is this child's need for medical care, mental health, or educational services because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A23]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A23. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

1 ☐ YES
2 ☐ NO *[GO TO A24]*

→ ***[IF YES]*** **is this child's limitation in abilities because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A24]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A24. Does this child need or get special therapy, such as physical, occupational, or speech therapy?

1 ☐ YES
2 ☐ NO *[GO TO A25]*

→ ***[IF YES]*** **is this because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A25]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A25. Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?

1 ☐ YES
2 ☐ NO *[GO TO A26]*

→ ***[IF YES]*** **has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

IF RESPONDENT HAS ANOTHER CHILD, CONTINUE WITH A26. ELSE CONTINUE WITH SECTION B.

A26. CHILD 3

What is this child's first name, initials, or nickname?

A27. Is this child of Hispanic, Latino, or Spanish origin?

1 ☐ No, not of Hispanic, Latino, or Spanish origin
2 ☐ Yes, Mexican, Mexican American, Chicano
3 ☐ Yes, Puerto Rican
4 ☐ Yes, Cuban
5 ☐ Yes, another Hispanic, Latino, or Spanish origin, *please specify:*

A28. What is this child's race or ethnicity? *SELECT ONE OR MORE.*

1 ☐ WHITE
2 ☐ BLACK OR AFRICAN AMERICAN
3 ☐ AMERICAN INDIAN OR ALASKA NATIVE, *PLEASE SPECIFY:*

4 ☐ ASIAN INDIAN
5 ☐ CHINESE
6 ☐ FILIPINO
7 ☐ JAPANESE
8 ☐ KOREAN
9 ☐ VIETNAMESE
10 ☐ OTHER ASIAN, *PLEASE SPECIFY:*

11 ☐ NATIVE HAWAIIAN
12 ☐ GUAMANIAN OR CHAMORRO
13 ☐ SAMOAN
14 ☐ TONGAN
15 ☐ SAIPANESE
16 ☐ MORTLOCKESE
17 ☐ KOSRAEN
18 ☐ CAROLINIAN
19 ☐ PALAUAN
20 ☐ POHNPEIAN
21 ☐ YAPESE
22 ☐ CHUUKESE
23 ☐ MARSHALLESE
24 ☐ OTHER PACIFIC ISLANDER, *PLEASE SPECIFY:*

A29. What is this child's sex?

1 ☐ MALE
2 ☐ FEMALE

A30. How old is this child? If the child is less than one month old, round age in months to 1.

☐☐ YEARS (OR) ☐☐ MONTHS
IF THIS CHILD IS YOUNGER THAN 4 YEARS OLD, GO TO A32.

A31. PUERTO RICO: How well does this child speak Spanish?

ALL OTHER JURISDICTIONS: How well does this child speak English?

1 ☐ Very well
2 ☐ Well
3 ☐ Not well
4 ☐ Not at all

A32. Does this child <u>currently</u> need or use medicine prescribed by a doctor, other than vitamins?

1 ☐ YES
2 ☐ NO *[GO TO A33]*

→ ***[IF YES]* is this child's need for prescription medicine because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A33]*

→ ***[IF YES]* is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A33. Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?

1 ☐ YES
2 ☐ NO *[GO TO A34]*

→ ***[IF YES]*** **is this child's need for medical care, mental health, or educational services because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A34]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A34. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

1 ☐ YES
2 ☐ NO *[GO TO A35]*

→ ***[IF YES]*** **is this child's limitation in abilities because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A35]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A35. Does this child need or get special therapy, such as physical, occupational, or speech therapy?

1 ☐ YES
2 ☐ NO *[GO TO A36]*

→ ***[IF YES]*** **is this because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A36]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A36. Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?

1 ☐ YES
2 ☐ NO *[GO TO A37]*

→ ***[IF YES]*** **has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

IF RESPONDENT HAS ANOTHER CHILD, CONTINUE WITH A37. ELSE CONTINUE WITH SECTION B.

A37. CHILD 4

What is this child's first name, initials, or nickname?

A38. Is this child of Hispanic, Latino, or Spanish origin?

1 ☐ No, not of Hispanic, Latino, or Spanish origin
2 ☐ Yes, Mexican, Mexican American, Chicano
3 ☐ Yes, Puerto Rican
4 ☐ Yes, Cuban
5 ☐ Yes, another Hispanic, Latino, or Spanish origin, *please specify:*

A39. What is this child's race or ethnicity? *SELECT ONE OR MORE.*

1 ☐ WHITE
2 ☐ BLACK OR AFRICAN AMERICAN
3 ☐ AMERICAN INDIAN OR ALASKA NATIVE, *PLEASE SPECIFY:*
4 ☐ ASIAN INDIAN
5 ☐ CHINESE
6 ☐ FILIPINO
7 ☐ JAPANESE
8 ☐ KOREAN
9 ☐ VIETNAMESE
10 ☐ OTHER ASIAN, *PLEASE SPECIFY:*
11 ☐ NATIVE HAWAIIAN
12 ☐ GUAMANIAN OR CHAMORRO
13 ☐ SAMOAN
14 ☐ TONGAN
15 ☐ SAIPANESE
16 ☐ MORTLOCKESE
17 ☐ KOSRAEN
18 ☐ CAROLINIAN
19 ☐ PALAUAN
20 ☐ POHNPEIAN
21 ☐ YAPESE
22 ☐ CHUUKESE
23 ☐ MARSHALLESE
24 ☐ OTHER PACIFIC ISLANDER, *PLEASE SPECIFY:*

A40. What is this child's sex?

1 ☐ MALE
2 ☐ FEMALE

A41. How old is this child? If the child is less than one month old, round age in months to 1.

☐☐ YEARS (OR) ☐☐ MONTHS

IF THIS CHILD IS YOUNGER THAN 4 YEARS OLD, GO TO A43

A42. PUERTO RICO: How well does this child speak Spanish?

ALL OTHER JURISDICTIONS: How well does this child speak English?

1 ☐ Very well
2 ☐ Well
3 ☐ Not well
4 ☐ Not at all

A43. Does this child <u>currently</u> need or use medicine prescribed by a doctor, other than vitamins?

1 ☐ YES
2 ☐ NO *[GO TO A44]*

→ ***[IF YES]*** **is this child's need for prescription medicine because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A44]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A44. Does this child need or use more medical care, mental health, or educational services than is usual for most children of the same age?

1 ☐ YES
2 ☐ NO *[GO TO A45]*

→ ***[IF YES]*** **is this child's need for medical care, mental health, or educational services because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A45]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A45. Is this child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

1 ☐ YES
2 ☐ NO *[GO TO A46]*

→ ***[IF YES]*** **is this child's limitation in abilities because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A46]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A46. Does this child need or get special therapy, such as physical, occupational, or speech therapy?

1 ☐ YES
2 ☐ NO *[GO TO A47]*

→ ***[IF YES]*** **is this because of <u>any</u> medical, behavioral, or other health condition?**

1 ☐ YES
1 ☐ NO *[GO TO A47]*

→ ***[IF YES]*** **is this a condition that has lasted or is expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

A47. Does this child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?

1 ☐ YES
2 ☐ NO *[GO TO A48]*

→ ***[IF YES]*** **has his or her emotional, developmental, or behavioral problem lasted or is it expected to last 12 months or longer?**

1 ☐ YES
1 ☐ NO

IF THERE ARE NO OTHER CHILDREN, CONTINUE TO SECTION B.

IF THERE ARE MORE THAN FOUR CHILDREN 0-17 YEARS OLD WHO USUALLY LIVE OR STAY AT THIS ADDRESS, LIST THE AGE AND SEX FOR EACH. DO NOT REPEAT INFORMATION FOR CHILDREN ALREADY INCLUDED FOR CHILD 1 THROUGH CHILD 4.

A48. CHILD 5

What is this child's first name, initials, or nickname?

A49. How old is this child?

☐☐ YEARS (OR) ☐☐ MONTHS

A50. What is this child's sex?

1 ☐ MALE
2 ☐ FEMALE

A51. CHILD 6

What is this child's first name, initials, or nickname?

A52. How old is this child?

☐☐ YEARS (OR) ☐☐ MONTHS

A53. What is this child's sex?

1 ☐ MALE
2 ☐ FEMALE

A54. CHILD 7

What is this child's first name, initials, or nickname?

A55. How old is this child?

☐☐ YEARS (OR) ☐☐ MONTHS

A56. What is this child's sex?

1 ☐ MALE
2 ☐ FEMALE

A57. CHILD 8

What is this child's first name, initials, or nickname?

A58. How old is this child?

☐☐ YEARS (OR) ☐☐ MONTHS

A59. What is this child's sex?

1 ☐ MALE
2 ☐ FEMALE

A60. CHILD 9

What is this child's first name, initials, or nickname?

A61. How old is this child?

☐☐ YEARS (OR) ☐☐ MONTHS

A62. What is this child's sex?

1 ☐ MALE
2 ☐ FEMALE

A63. CHILD 10

What is this child's first name, initials, or nickname?

A64. How old is this child?

☐☐ YEARS (OR) ☐☐ MONTHS

A65. What is this child's sex?

1 ☐ MALE
2 ☐ FEMALE

Section B. This Child's Health (PROGRAMMER: Add Timestamp)

We now have some follow up questions to ask about [SPECIFY CHILD]. These questions will collect more detailed information on various aspects of this child's health including his or her health status, visits to health care providers, health care costs, and health insurance coverage. We have selected only one child per household in an effort to minimize the amount of time necessary to complete the follow-up questions.

B1. In general, how would you describe this child's health?

1 ☐ Excellent
2 ☐ Very Good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

B2. How would you describe the condition of this child's teeth?

1 ☐ Excellent
2 ☐ Very Good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor
6 ☐ CHILD DOES NOT HAVE TEETH
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

B3. **During the past 12 months, has this child had frequent or chronic difficulty with any of the following?**

		YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
B3a.	**Breathing or other respiratory problems (such as wheezing or shortness of breath)**	1 ☐	2 ☐	77 ☐	99 ☐
B3b.	**Eating or swallowing because of a health condition**	1 ☐	2 ☐	77 ☐	99 ☐
B3c.	**Digesting food, including stomach/intestinal problems, constipation, or diarrhea**	1 ☐	2 ☐	77 ☐	99 ☐
B3d.	**Repeated or chronic physical pain, including headaches or other back or body pain**	1 ☐	2 ☐	77 ☐	99 ☐
B3e.	**Using his or her hands**	1 ☐	2 ☐	77 ☐	99 ☐
B3f.	**Coordination or moving around**	1 ☐	2 ☐	77 ☐	99 ☐
B3g.	**Toothaches**	1 ☐	2 ☐	77 ☐	99 ☐
B3h.	**Bleeding gums**	1 ☐	2 ☐	77 ☐	99 ☐
B3i.	**Decayed teeth or cavities**	1 ☐	2 ☐	77 ☐	99 ☐
B3j.	**Ear infections**	1 ☐	2 ☐	77 ☐	99 ☐

B4. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]***

Does this child have any of the following?

		YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
B4a.	**Deafness or problems with hearing**	1 ☐	2 ☐	77 ☐	99 ☐
B4b.	**Blindness or problems with seeing, even when wearing glasses**	1 ☐	2 ☐	77 ☐	99 ☐

B5. Has a doctor or other health care provider ever told you that this child has any of the following? If yes, does this child currently have the condition?

		Ever?	Currently?	DON'T KNOW	PREFER NOT TO ANSWER
B5a.	**Asthma**	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐
B5b.	**Diabetes**	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐
B5c.	**Down Syndrome**	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐
B5d.	**Frequent or Severe Headaches, including Migraine**	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐
B5e.	**Brain Injury, Concussion or Head Injury**	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐
B5f.	**Anxiety**	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐
B5g.	**Depression**	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐
B5h.	**Autism, ASD, Autism Spectrum Disorder (ASD), Asperger's Disorder, or Pervasive Developmental Disorder (PDD)**	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐
B5i.	**Attention Deficit Disorder (ADD) or Attention Deficit/Hyperactivity Disorder (ADHD)**	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐
B5j.	**Developmental Delay**	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐
B5k.	**Behavior or Conduct Problems**	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐
B5l.	**Intellectual Disability (also known as mental retardation)**	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐

	Ever?	Currently?	DON'T KNOW	PREFER NOT TO ANSWER
B5m. Speech or Other Language Disorder	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐
B5n. Learning Disability	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐
B5o. Another Mental Health Condition	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO	77 ☐	99 ☐

B6. <u>During the past 12 months</u>, how often has this child's health conditions or problems affected his or her ability to do things other children his or her age do?

1 ☐ THIS CHILD DOES NOT HAVE ANY HEALTH CONDITIONS *[GO TO B8]*
2 ☐ Never *[GO TO B8]*
3 ☐ Sometimes
4 ☐ Usually
5 ☐ Always
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

B7. To what extent do this child's health conditions or problems affect his or her ability to do things?

1 ☐ Very little
2 ☐ Somewhat
3 ☐ A great deal
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

B8. ***[ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]***

Has a doctor or other health care provider <u>ever</u> told you that this child has Substance Abuse Disorder? Substance Abuse Disorder occurs when the frequent or continued use of alcohol and/or drugs have caused health problems, disability, and failure to meet major responsibilities at work, school, or home.

1 ☐ YES
2 ☐ NO *[GO TO B9]*
1 ☐ DON'T KNOW *[GO TO B9]*
1 ☐ PREFER NOT TO ANSWER *[GO TO B9]*

→ ***[IF YES]*** **does this child <u>currently</u> have the condition?**

1 ☐ YES
1 ☐ NO *[GO TO B9]*
1 ☐ DON'T KNOW *[GO TO B9]*
1 ☐ PREFER NOT TO ANSWER *[GO TO B9]*

→ ***[IF YES]*** **is it:**

1 ☐ Mild
1 ☐ Moderate
2 ☐ Severe
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

B9. ***[ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]***

Does this child have any of the following?

		YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
B9a.	**Serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition**	1 ☐	2 ☐	77 ☐	99 ☐
B9b.	**Serious difficulty walking or climbing stairs**	1 ☐	2 ☐	77 ☐	99 ☐
B9c.	**Difficulty dressing or bathing**	1 ☐	2 ☐	77 ☐	99 ☐
B9d.	**Difficulty doing errands alone, such as visiting a doctor's office or shopping, because of a physical, mental, or emotional condition**	1 ☐	2 ☐	77 ☐	99 ☐
B9e.	**Deafness or problems with hearing**	1 ☐	2 ☐	77 ☐	99 ☐
B9f.	**Blindness or problems with seeing, even when wearing glasses**	1 ☐	2 ☐	77 ☐	99 ☐

B10. **Has a doctor or other health care provider ever told you that this child had…**

		YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
B10a.	**Rheumatic heart disease**	1 ☐	2 ☐	77 ☐	99 ☐
B10b.	**Rheumatic fever**	1 ☐	2 ☐	77 ☐	99 ☐
B10c.	**Impetigo (or other skin infections)**	1 ☐	2 ☐	77 ☐	99 ☐

[IF YES TO RHEUMATIC HEART DISEASE OR FEVER] **Do they take any medication for this condition?**

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

→ ***[IF YES]*** **Do they take Oral medication (pills) or get a shot?**

1 ☐ ORAL MEDICATION (PILLS) *[GO TO B11]*
1 ☐ SHOT *[GO TO B11]*

→ ***[IF NO]*** **Why not? CHECK ALL THAT APPLY.**

1 ☐ Cannot afford the cost.
1 ☐ No transportation.
3 ☐ No-one to take my child to hospital.
4 ☐ Not important
5 ☐ OTHER REASON, *PLEASE SPECIFY* ____
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

B11. Has a doctor or other health care provider ever told you that this child had blood problems such as leukemia, anemia or sickle cell disease? Please do not include Sickle Cell Trait.

[READ IF NECESSARY]: Children with anemia have problems with their blood that can cause them to be very tired.

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

Now I'm going to ask you a few questions about injury prevention for your child.

B12. Have you or any other adult in your child's life discussed avoidance of violence or <u>prevention of injury with your child</u>? *For example, the dangers of playing on the road, climbing trees, and swimming in the ocean.*

1 ☐ Yes, avoidance of violence
2 ☐ Yes, prevention of injury
3 ☐ Both
4 ☐ Neither
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

B13. Do you accompany your child during outdoor activities like swimming or playing?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

B14. ***[ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]***

When your child rides a bicycle, how often does he or she wear a helmet?

1 ☐ My child does not ride a bicycle
2 ☐ Never wears a helmet
3 ☐ Rarely wears a helmet
4 ☐ Sometimes wears a helmet
5 ☐ Most of the time wears a helmet
6 ☐ Always wears a helmet
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

B15. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-11 YEARS OLD]***

How often does your child ride in a child safety seat or booster seat?

1 ☐ Always
2 ☐ Nearly always
3 ☐ Sometimes
4 ☐ Seldom
5 ☐ Never *[IF CHILD 0-5 YEARS OLD, GO TO B17; IF CHILD 6-11 YEARS OLD, GO TO C1]*
6 ☐ MY CHILD DOES NOT RIDE IN CARS *[IF CHILD 0-5 YEARS OLD, GO TO B17; IF CHILD 6-11 YEARS OLD, GO TO C1]*
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

B16. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-11 YEARS OLD]***

Where is your child's safety seat located in your car?

1 ☐ Front passenger
2 ☐ Behind passenger
3 ☐ Behind driver
4 ☐ Middle of the back seat
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

B17. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]***

Are your child's immunizations up to date?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

Section C. This Child as an Infant (PROGRAMMER: Add Timestamp)

C1. **Was this child born more than 3 weeks before his or her due date?**

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

C2. **How much did he or she weigh when born? Answer in pounds and ounces <u>or</u> kilograms and grams. Provide your best estimate.** [IF NEEDED, READ: YOUR BEST GUESS IS FINE. IT DOES NOT HAVE TO BE EXACT].

☐☐ POUNDS AND ☐☐ OUNCES

☐☐ KILOGRAMS AND ☐☐ GRAMS

1 ☐ DON'T KNOW

1 ☐ PREFER NOT TO ANSWER

C3. **How old were you when this child was born?**

☐☐ YEARS

C4. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-1 YEAR OLD]***

In which position do you most often lay this baby down to sleep now?

1 ☐ On his or her side

2 ☐ On his or her back

3 ☐ On his or her stomach

1 ☐ DON'T KNOW

1 ☐ PREFER NOT TO ANSWER

C5. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD. ELSE GO TO SECTION D]***

Was this child EVER breastfed or fed breast milk?

1 ☐ YES

2 ☐ NO *[GO TO C6]*

1 ☐ DON'T KNOW *[GO TO C6]*

1 ☐ PREFER NOT TO ANSWER *[GO TO C6]*

→ ***[IF YES]*** **how old was this child when he or she <u>completely</u> stopped breastfeeding or being fed breast milk?**

☐☐ DAYS (OR)

☐☐ WEEKS (OR)

☐☐ MONTHS (OR)

☐☐ YEARS

☐ CHILD IS STILL BREASTFEEDING

1 ☐ DON'T KNOW

1 ☐ PREFER NOT TO ANSWER

C6. **How old was this child when he or she was <u>first</u> fed anything other than breast milk or formula? Include juice, cow's milk, sugar water, baby food or cereal, or anything else that your child might have been given, even water.**

☐☐ DAYS (OR) ☐☐ WEEKS (OR) ☐☐ MONTHS

☐ AT BIRTH

☐ CHECK THIS BOX IF CHILD HAS NEVER BEEN FED ANYTHING OTHER THAN BREAST MILK OR FORMULA

1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

Section D. Health Care Services (PROGRAMMER: Add Timestamp)

D1. <u>During the past 12 months,</u> 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?

1 ☐ YES
2 ☐ NO *[GO TO D2]*
1 ☐ DON'T KNOW *[GO TO D2]*
1 ☐ PREFER NOT TO ANSWER *[GO TO D2]*

→ ***[IF YES]*** **<u>During the past 12 months,</u> 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.**

1 ☐ 0 VISITS
1 ☐ 1 VISIT
2 ☐ 2 OR MORE VISITS
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

D2. Are you concerned about this child's weight?

1 ☐ Yes, it's too high
2 ☐ Yes, it's too low
3 ☐ No, I am not concerned
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

D3. What is this child's <u>current</u> height (or length)? Please provide your best estimate. [IF NEEDED, READ: YOUR BEST GUESS IS FINE. IT DOES NOT HAVE TO BE EXACT].

☐☐ FEET AND ☐☐ INCHES
☐☐ METERS AND ☐☐ CENTIMETERS

1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

[*DO NOT READ TO RESPONDENT*] How was the measurement taken?

1 ☐ RESPONDENT ESTIMATE
2 ☐ MEASURED ON SITE

D4. **How much does this child <u>currently</u> weigh? Please provide your best estimate.** [IF NEEDED, READ: YOUR BEST GUESS IS FINE. IT DOES NOT HAVE TO BE EXACT].

☐☐☐ POUNDS AND ☐☐ OUNCES

☐☐☐ KILOGRAMS AND ☐☐ GRAMS

1 ☐ DON'T KNOW

1 ☐ PREFER NOT TO ANSWER

[*DO NOT READ TO RESPONDENT*] How was the measurement taken?

2 ☐ RESPONDENT ESTIMATE

3 ☐ MEASURED ON SITE

D5. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]***

<u>During the past 12 months,</u> did this child's doctors or other health care providers ask if you have concerns about this child's learning, development, or behavior?

1 ☐ YES

2 ☐ NO

1 ☐ DON'T KNOW

1 ☐ PREFER NOT TO ANSWER

D6. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]***

[IF THIS CHILD IS YOUNGER THAN 9 MONTHS, GO TO D7]

<u>During the past 12 months,</u> did a doctor or other health care provider have you or another caregiver fill out a questionnaire about specific concerns or observations 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.

1 ☐ YES

2 ☐ NO *[GO TO D7]*

1 ☐ DON'T KNOW *[GO TO D7]*

1 ☐ PREFER NOT TO ANSWER *[GO TO D7]*

→ ***[IF THIS CHILD IS 9-23 MONTHS]***

Did the questionnaire ask about your concerns or observations about: CHECK ALL THAT APPLY

1 ☐ How this child talks or makes speech sounds?

1 ☐ How this child interacts with you and others?

1 ☐ DON'T KNOW

1 ☐ PREFER NOT TO ANSWER

[IF THIS CHILD IS 2-5 YEARS]

Did the questionnaire ask about your concerns or observations about: CHECK ALL THAT APPLY.

1 ☐ Words and phrases this child uses and understands?

2 ☐ How this child behaves and gets along with you and others?

1 ☐ DON'T KNOW

1 ☐ PREFER NOT TO ANSWER

D7. Is there a place that this child <u>usually</u> goes when he or she is sick or you or another caregiver needs advice about his or her health?

1 ☐ YES
2 ☐ NO *[GO TO D8]*
1 ☐ DON'T KNOW *[GO TO D8]*
1 ☐ PREFER NOT TO ANSWER *[GO TO D8]*

***[IF YES]* where does this child <u>usually</u> go?**

1 ☐ Private doctor's office
1 ☐ Hospital emergency room
2 ☐ Hospital outpatient department
3 ☐ Community health clinic, community clinic, or public health clinic
4 ☐ School (nurse's office, athletic trainer's office)
5 ☐ Village dispensary
6 ☐ Some other place, *PLEASE SPECIFY* _____
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

D8. Is there a place that this child <u>usually</u> goes when he or she needs routine preventive care, such as a physical examination or well-child check-up?

1 ☐ YES
2 ☐ NO *[GO TO D9]*
1 ☐ DON'T KNOW *[GO TO D9]*
1 ☐ PREFER NOT TO ANSWER *[GO TO D9]*

***[IF YES]* is this the same place this child goes when he or she is sick?**

1 ☐ YES
1 ☐ NO

D9. <u>During the past 12 months</u>, did this child use any of the following types of health care or services? *Check all that apply*. *Alternative health care can include acupuncture, chiropractic care, relaxation therapies, traditional herbal medicine, and others. Some therapies involve seeing a health care provider, while others can be done on your own.*

1 ☐ Medical Care
2 ☐ Vision Care
3 ☐ Hearing Care
4 ☐ Dental or Oral Care
5 ☐ Mental Health Services
6 ☐ Alternative Health Care or Treatment
7 ☐ None of these *[GO TO D10]*
1 ☐ DON'T KNOW *[GO TO D10]*
1 ☐ PREFER NOT TO ANSWER *[GO TO D10]*

***[IF VISION CARE]* What kind of place or places did this child have his or her vision tested? Check all that apply.**

1 ☐ Eye doctor or eye specialist (ophthalmologist, optometrist) office
1 ☐ Pediatrician or other private doctor's office
2 ☐ Community health clinic, community clinic, or public health clinic
3 ☐ School
4 ☐ Another place, *PLEASE SPECIFY* _____

D10. **<u>During the past 12 months,</u> was there any time when this child needed health care but it was not received or not available? By health care, we mean medical care as well as other kinds of care like dental care, vision care, and mental health services.**

1 ☐ YES
2 ☐ NO *[GO TO D12]*
1 ☐ DON'T KNOW *[GO TO D12]*
1 ☐ PREFER NOT TO ANSWER *[GO TO D12]*

***[IF YES]* which types of care were not received or not available? Check all that apply.**

1 ☐ Medical Care
1 ☐ Dental or Oral Care
2 ☐ Vision Care
3 ☐ Hearing Care
4 ☐ Mental Health Services
5 ☐ [redacted]

D11. **Which of the following contributed to this child not receiving needed health services:**

		YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
D11a.	**This child was not eligible for the services?**	1 ☐	2 ☐	77 ☐	99 ☐
D11b.	**The services this child needed were not available in your area?**	1 ☐	2 ☐	77 ☐	99 ☐
D11c.	**There were problems getting an appointment when this child needed one?**	1 ☐	2 ☐	77 ☐	99 ☐
D11d.	**There were problems with getting transportation or child care?**	1 ☐	2 ☐	77 ☐	99 ☐
D11e.	**The (clinic/doctor's) office wasn't open when this child needed care?**	1 ☐	2 ☐	77 ☐	99 ☐
D11f.	**There were issues related to cost?**	1 ☐	2 ☐	77 ☐	99 ☐

D12. **In the past 12 months, has this child been admitted to the hospital?** *Please include emergency room visits and overnight hospital stays.*

1 ☐ Yes
2 ☐ No
1 ☐ DON'T KNOW
1 ☐ REFUSED

[IF YES] In the past 12 months, how many times has this child been admitted to the hospital for an injury? By 'injury', we mean physical harm or damage caused by an accident or an attack. Injuries could include, but are not limited to, broken bones, strains, cuts, burns, bites/stings, or harm from being hit by something.

☐☐ TIMES

1 ☐ DON'T KNOW

Section E. Experience with This Child's Health Care Providers (PROGRAMMER: Add Timestamp)

E1. 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.

1 ☐ YES, ONE PERSON
2 ☐ YES, MORE THAN ONE PERSON
3 ☐ NO

E2. <u>During the past 12 months,</u> did this child need a referral to see any doctors or receive any services?

1 ☐ YES
2 ☐ NO *[GO TO E3]*
1 ☐ DON'T KNOW *[GO TO E3]*
1 ☐ PREFER NOT TO ANSWER *[GO TO E3]*

→ ***[IF YES]* how much of a problem was it to get referrals?**

1 ☐ Not a problem
1 ☐ Small problem
2 ☐ Big problem

E3. *[ANSWER THE FOLLOWING QUESTIONS ONLY IF THIS CHILD HAD A HEALTH CARE VISIT IN THE PAST 12 MONTHS. OTHERWISE, GO TO E4.]*

<u>During the past 12 months,</u> how often did this child's doctors or other health care providers:

		Always	Usually	Sometimes	Never	DON'T KNOW	PREFER NOT TO ANSWER
E3a.	**Spend enough time with this child?**	1 ☐	2 ☐	3 ☐	4 ☐	77 ☐	99 ☐
E3b.	**Listen carefully to you?**	1 ☐	2 ☐	3 ☐	4 ☐	77 ☐	99 ☐
E3c.	**Show sensitivity to your family's values and customs?**	1 ☐	2 ☐	3 ☐	4 ☐	77 ☐	99 ☐
E3d.	**Provide the specific information you needed concerning this child?**	1 ☐	2 ☐	3 ☐	4 ☐	77 ☐	99 ☐
E3e.	**Help you feel like a partner in this child's care?**	1 ☐	2 ☐	3 ☐	4 ☐	77 ☐	99 ☐

E4. Does anyone help you arrange or coordinate this child's care among the different doctors or services that this child uses?

1 ☐ YES
2 ☐ NO
3 ☐ DID NOT SEE MORE THAN ONE HEALTH CARE PROVIDER IN PAST 12 MONTHS *[GO TO E7]*

E5. <u>During the past 12 months,</u> 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?

1 ☐ YES
2 ☐ NO *[GO TO E6]*

→ ***[IF YES]*** **<u>During the past 12 months,</u> how often did you get as much help as you wanted with arranging or coordinating this child's health care?**

1 ☐ Usually
1 ☐ Sometimes
2 ☐ Never

E6. Overall, how satisfied are you with the communication among this child's doctors and other health care providers?

1 ☐ Very satisfied
2 ☐ Somewhat satisfied
3 ☐ Somewhat dissatisfied
4 ☐ Very dissatisfied
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

E7. *[ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]*

Do any of this child's doctors or other health care providers treat only children?

1 ☐ YES
2 ☐ NO *[GO TO E8]*
1 ☐ DON'T KNOW *[GO TO E8]*
1 ☐ PREFER NOT TO ANSWER *[GO TO E8]*

→ ***[IF YES]*** **have they talked with you about having this child eventually see doctors or other health care providers who treat adults?**

1 ☐ YES
1 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

E8. ***[ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]***

Has this child's doctor or other health care provider actively worked with this child to:

		YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
E8a.	**Think about and plan for his or her future. For example, by taking time to discuss future plans about education, work, relationships, and development of independent living skills?**	1 ☐	2 ☐	77 ☐	99 ☐
E8b.	**Make positive choices about his or her health. For example, by eating healthy, getting regular exercise, not using tobacco, alcohol or other drugs, or delaying sexual activity?**	1 ☐	2 ☐	77 ☐	99 ☐
E8c.	**Gain skills to manage his or her health and health care. For example, by understanding current health needs, knowing what to do in a medical emergency, or taking medications he or she may need?**	1 ☐	2 ☐	77 ☐	99 ☐
E8d.	**Understand the changes in health care that happen at age 18. For example, by understanding changes in privacy, consent, access to information, or decision-making?**	1 ☐	2 ☐	77 ☐	99 ☐

E9. ***[ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]***

Have this child's doctors or other health care providers worked with you and this child to create a written plan to meet his or her health goals and needs?

1 ☐ YES
2 ☐ NO *[GO TO E10]*
1 ☐ DON'T KNOW *[GO TO E10]*
1 ☐ PREFER NOT TO ANSWER *[GO TO E10]*

[IF YES] **does this plan identify specific health goals for this child and any health needs or problems this child may have and how to get these needs met?**

1 ☐ YES
1 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

Did you and this child receive a written copy of this plan of care?

1 ☐ YES
1 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

Is this plan <u>currently</u> up-to-date for this child?

1 ☐ YES
1 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

E10. Eligibility for health insurance often changes in young adulthood. Do you know how this child will be insured as he or she becomes an adult?

1 ☐ YES *[GO TO F]*
2 ☐ NO

→ ***[IF NO]*** **has anyone discussed with you how to obtain or keep some type of health insurance coverage as this child becomes an adult?**

1 ☐ YES
1 ☐ NO

Section F. This Child's Health Insurance Coverage (PROGRAMMER: Add Timestamp)

F1. <u>During the past 12 months,</u> was this child <u>ever</u> covered by <u>any</u> kind of health insurance or health coverage plan? *This includes medical savings accounts, supplemental health, and government funded or subsidized insurance programs.*

1 ☐ Yes, this child was covered all 12 months or, if under 1 year old, since birth *[GO TO F4]*
2 ☐ Yes, but this child had a gap in coverage
3 ☐ No

F2. Please indicate whether each of the following is a reason this child was not covered by health insurance <u>during the past 12 months</u>:

		YES	NO
F2a.	**Change in employer or employment status**	1 ☐	2 ☐
F2b.	**Cancellation from inability to pay insurance fee**	1 ☐	2 ☐
F2c.	**Dropped coverage because it was unaffordable**	1 ☐	2 ☐
F2d.	**Dropped coverage because benefits were inadequate**	1 ☐	2 ☐
F2e.	**Dropped coverage because choice of health care providers was inadequate**	1 ☐	2 ☐
F2f.	**Problems with application or renewal process**	1 ☐	2 ☐
F2g.	**Another reason, *please specify*** ☐	1 ☐	2 ☐

F3. Is this child <u>currently</u> covered by <u>any</u> kind of health insurance or health coverage plan?

1 ☐ YES
2 ☐ NO *[GO TO SECTION G]*
1 ☐ DON'T KNOW *[GO TO SECTION G]*
1 ☐ PREFER NOT TO ANSWER *[GO TO SECTION G]*

F4. Is this child covered by any of the following types of health insurance or health coverage plans? [*Interviewer Note*: O*nly read jurisdiction-specific insurance types for your jurisdiction].*

		YES	NO
F4a.	**Private health insurance**	1 ☐	2 ☐
F4b.	**Insurance through your (or your spouse's) current or former employer or union**	1 ☐	2 ☐
F4c.	**Medicaid, Medical Assistance, or any kind of government assistance plan** (*includes Guam Medical Indigent Program, Palau National Health Insurance Program, and Puerto Rico Government Health Plan*)	1 ☐	2 ☐
F4d.	**Other government funded or subsidized insurance** (*includes Micronesia MiCare or Chuuk State, Marshall Islands Public Insurance, and Marshall Islands Supplemental Health Fund)*	1 ☐	2 ☐
F4e.	**Medical savings account**	1 ☐	2 ☐
F4f.	**CHIP (Children's Health Insurance Program)**	1 ☐	2 ☐
F4g.	**TRICARE or other military health care**	1 ☐	2 ☐
F4h.	**Indian Health Service**	1 ☐	2 ☐
F4i.	**Another type, *please specify***	1 ☐	2 ☐

F5. How often does this child's health insurance offer benefits or cover services that meet this child's needs? *Examples include dental or vision services, prescription medications, emergency room visits, maternity services, mental health services, and yearly check-ups or screenings.*

1 ☐ Always
2 ☐ Usually
3 ☐ Sometimes
4 ☐ Never
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

F6. How often does this child's health insurance allow him or her to see the health care providers he or she needs?

1 ☐ Always
2 ☐ Usually
3 ☐ Sometimes
4 ☐ Never
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

Section G. Providing for This Child's Health (PROGRAMMER: Add Timestamp)

G1. Including co-pays and amounts from medical savings accounts, 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.

1 ☐ $0 (NO MEDICAL OR HEALTH-RELATED EXPENSES) *[GO TO G4]*
2 ☐ $1-$249
3 ☐ $250-$499
4 ☐ $500-$999
5 ☐ $1,000-$5,000
6 ☐ MORE THAN $5,000
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

G2. How often are these costs reasonable?

1 ☐ Always
2 ☐ Usually
3 ☐ Sometimes
4 ☐ Never
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

G3. During the past 12 months, did your family have problems paying for any of this child's medical or health care bills?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

G4. During the past 12 months, have you or other family members:

		YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
G4a.	**Stopped working because of this child's health or health conditions?**	1 ☐	2 ☐	77 ☐	99 ☐
G4b.	**Cut down on the hours you work because of this child's health or health conditions?**	1 ☐	2 ☐	77 ☐	99 ☐
G4c.	**Avoided changing jobs because of concerns about maintaining health insurance for this child?**	1 ☐	2 ☐	77 ☐	99 ☐
G4d.	**Received help from extended family members?**	1 ☐	2 ☐	77 ☐	99 ☐

G5. <u>In an average week,</u> 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.

1 ☐ This child does not need health care provided on a weekly basis
2 ☐ No at home care was provided by me or other family members
3 ☐ Less than 1 hour per week
4 ☐ 1-4 hours per week
5 ☐ 5-10 hours per week
6 ☐ 11 or more hours per week
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

G6. <u>In an average week,</u> 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?

1 ☐ This child does not need health care provided on a weekly basis
2 ☐ No at home care was provided by me or other family members
3 ☐ Less than 1 hour per week
4 ☐ 1-4 hours per week
5 ☐ 5-10 hours per week
6 ☐ 11 or more hours per week
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

Section H. This Child's Learning (PROGRAMMER: Add Timestamp)

H1. <u>On an average weekday,</u> about how much time does this child usually spend in front of a TV watching TV programs, videos, or playing video games?

1 ☐ None
2 ☐ Less than 1 hour
3 ☐ 1 hour
4 ☐ 2 hours
5 ☐ 3 hours
6 ☐ 4 or more hours
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

H2. <u>On an average weekday,</u> about how much time does this child usually spend with computers, cell phones, handheld video games, and other electronic devices, doing things other than schoolwork?

1 ☐ None
2 ☐ Less than 1 hour
3 ☐ 1 hour
4 ☐ 2 hours
5 ☐ 3 hours
6 ☐ 4 or more hours
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

H3. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]***

How well is this child learning to do things for him or herself?

1 ☐ Very well
2 ☐ Somewhat
3 ☐ Poorly
4 ☐ Not at all
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

H4. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]***

How confident are you that this child will be successful in elementary or primary school?

1 ☐ Very confident
2 ☐ Mostly confident
3 ☐ Somewhat confident
4 ☐ Not confident at all
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

H5. ***[ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]***

<u>During the past 12 months,</u> about how many days did this child miss school because of illness or injury?

1 ☐ NO MISSED SCHOOL DAYS
2 ☐ 1-3 DAYS
3 ☐ 4-6 DAYS
4 ☐ 7-10 DAYS
5 ☐ 11 OR MORE DAYS
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

H6. ***[ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]***

<u>During the past 12 months,</u> how many times has this child's school contacted you or another adult in your household about any problems he or she is having with school?

1 ☐ NO TIMES
2 ☐ 1 TIME
3 ☐ 2 OR MORE TIMES
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

H7. ***[ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]***

The next 2 questions ask about bullying. Bullying is when 1 or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when two students of about the same strength or power argue or fight or tease each other in a friendly way.

Has your child ever been bullied on school property?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

H8. [ONLY ASK THIS QUESTION IF CHILD IS 12-17 YEARS OLD]

Has your child ever been electronically bullied? (Count being bullied through texting, Instagram, Facebook, or other social media.)

1 ☐ YES
2 ☐ NO
3 ☐ DON'T KNOW
4 ☐ PREFER NOT TO ANSWER

H9. ***[ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]***

Since starting kindergarten, has this child repeated any grades?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

H10. ***[ONLY ASK THIS QUESTION IF CHILD IS 6-17 YEARS OLD]***

During the past week, on how many days did this child exercise, play a sport, or participate in physical activity for at least 60 minutes?

1 ☐ 0 DAYS
2 ☐ 1-3 DAYS
3 ☐ 4-6 DAYS
4 ☐ EVERY DAY
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

Section I. About You and This Child (PROGRAMMER: Add Timestamp)

I1. How many times has this child moved to a new address or location since he or she was born?

☐☐ NUMBER OF TIMES
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

I2. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]***

During the past week, how many days did you or other family members read to this child?

1 ☐ 0 DAYS
2 ☐ 1-3 DAYS
3 ☐ 4-6 DAYS
4 ☐ EVERY DAY
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

I3. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]***

<u>During the past week,</u> how many days did you or other family members tell stories or sing songs to this child?

1 ☐ 0 DAYS
2 ☐ 1-3 DAYS
3 ☐ 4-6 DAYS
4 ☐ EVERY DAY
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

I4. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD]***

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

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

I5. DURING THE PAST 12 MONTHS, has this child had any health care visits by video or phone?

1 ☐ YES
2 ☐ NO

→ **[If yes] Were any of this child's health care visits by video or phone because of the coronavirus pandemic?**

1 ☐ YES
2 ☐ NO

I6. DURING THE PAST 12 MONTHS, did this child miss, delay or skip any PREVENTIVE check-ups because of the coronavirus pandemic?

1 ☐ YES
2 ☐ NO

I7. DURING THE PAST 12 MONTHS, has this child's regular daycare or other childcare arrangement been closed or unavailable at any time as a result of the coronavirus pandemic?

1 ☐ YES
2 ☐ NO

Section J. About Your Family and Household (PROGRAMMER: Add Timestamp)

J1. Does anyone living in your household use cigarettes, e-cigarettes or vapors, cigars, pipe tobacco, chewing tobacco, or chew betel nut? [READ IF NECESSARY: Please answer to the best of your ability. Betel nut is the seed of the fruit of the areca palm. It is also known as areca nut. Betel nut chewing is an important cultural practice in some regions in south and south-east Asia and the Asia Pacific. It is often chewed wrapped inside betel leaves (paan) or with tobacco (betel quid)].

1 ☐ YES
2 ☐ NO *[GO TO J3]*
1 ☐ DON'T KNOW *[GO TO J3]*
1 ☐ PREFER NOT TO ANSWER *[GO TO J3]*

J2. Does anyone smoke <u>inside</u> your home?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

IF PUERTO RICO, GO TO J5

J3. Has your child ever chewed betel nut? [READ IF NECESSARY: Betel nut is the seed of the fruit of the areca palm. It is also known as areca nut. Betel nut chewing is an important cultural practice in some regions in south and south-east Asia and the Asia Pacific. It is often chewed wrapped inside betel leaves (paan) or with tobacco (betel quid)].

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

J4. Are you aware of the effects of chewing betel nut?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

The next three questions are about money.

J5. <u>Since this child was born,</u> how often has it been very hard to get by on your family's income – hard to cover the basics like food or housing?

1 ☐ Never
2 ☐ Rarely
3 ☐ Somewhat often
4 ☐ Very often
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

J6. The next question is about whether you were able to afford the food you need. Which of these statements best describes the food situation in your household IN THE PAST 12 MONTHS?

1 ☐ We could always afford to eat good nutritious meals.
2 ☐ We could always afford enough to eat but not always the kinds of food we should eat.
3 ☐ Sometimes we could not afford enough to eat.
4 ☐ Often we could not afford enough to eat.
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

J7. At any time <u>during the past 12 months</u>, even for one month, did anyone in your family receive:

		YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
J7a.	**Cash assistance from a government welfare program?**	1 ☐	2 ☐	77 ☐	99 ☐
J7b.	[Programming note: Do not show for Puerto Rico] **Food Stamps or Supplemental Nutrition Assistance Program benefits (SNAP)?** [Programming note: For Puerto Rico Show the Following] **Nutrition Assistance Program (NAP) (known as PAN)**	1 ☐	2 ☐	77 ☐	99 ☐
J7c.	**Free or reduced-cost breakfasts or lunches at school?**	1 ☐	2 ☐	77 ☐	99 ☐
J7d.	[Programming note: Do not show for RMI, Palau, FSM, Puerto Rico] **Benefits from the Woman, Infants, and Children (WIC) Program?**	1 ☐	2 ☐	77 ☐	99 ☐

Section K. About You (PROGRAMMER: Add Timestamp)

COMPLETE THE QUESTIONS FOR EACH OF THE TWO ADULTS IN THE HOUSEHOLD WHO ARE THIS CHILD'S PRIMARY CAREGIVERS. IF THERE IS JUST ONE ADULT, PROVIDE ANSWERS FOR THAT ADULT.

K1. ADULT 1

How are you related to this child?

1 ☐ BIOLOGICAL PARENT
2 ☐ ADOPTIVE PARENT
3 ☐ STEP-PARENT
4 ☐ GRANDPARENT
5 ☐ FOSTER PARENT
6 ☐ AUNT OR UNCLE
7 ☐ OTHER: RELATIVE
8 ☐ OTHER: NON-RELATIVE

K2. What is your sex?

1 ☐ MALE
2 ☐ FEMALE

K3. What is your age?

☐☐ AGE IN YEARS

K4. What is the highest grade or year of school you have completed? *MARK ONE ONLY.*

1 ☐ 8TH GRADE OR LESS
2 ☐ 9TH-12TH GRADE; NO DIPLOMA
3 ☐ HIGH SCHOOL GRADUATE OR GED COMPLETED
4 ☐ COMPLETED A VOCATIONAL, TRADE, OR BUSINESS SCHOOL PROGRAM
5 ☐ SOME COLLEGE CREDIT, BUT NO DEGREE
6 ☐ ASSOCIATE DEGREE (AA, AS)
7 ☐ BACHELOR'S DEGREE (BA, BS, AB)
8 ☐ MASTER'S DEGREE (MA, MS, MSW, MBA)
9 ☐ DOCTORATE (PHD, EDD) OR PROFESSIONAL DEGREE (MD, DDS, DVM, JD)

K5. What is your marital status?

1 ☐ MARRIED *[GO TO K7]*
2 ☐ NEVER MARRIED
3 ☐ DIVORCED
4 ☐ SEPARATED
5 ☐ WIDOWED
1 ☐ PREFER NOT TO ANSWER *[GO TO K7]*

K6. Do you currently live with a romantic partner?

1 ☐ YES
2 ☐ NO
1 ☐ PREFER NOT TO ANSWER

K7. In general, how is your physical health?

1 ☐ Excellent
2 ☐ Very Good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

K8. In general, how is your mental or emotional health?

1 ☐ Excellent
2 ☐ Very Good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

K9. Were you employed at least 50 out of the past 52 weeks?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

K10. Is there another adult in this household who is this child's caregiver or guardian?

1 ☐ YES
2 ☐ NO *[GO TO SECTION L]*
1 ☐ PREFER NOT TO ANSWER *[GO TO SECTION L]*

This other caregiver or guardian will now be referred to as Adult 2.

K11. How is Adult 2 related to this child?

1 ☐ BIOLOGICAL PARENT
2 ☐ ADOPTIVE PARENT
3 ☐ STEP-PARENT
4 ☐ GRANDPARENT
5 ☐ FOSTER PARENT
6 ☐ AUNT OR UNCLE
7 ☐ OTHER: RELATIVE
8 ☐ OTHER: NON-RELATIVE

K12. What is Adult 2's sex?

1 ☐ MALE
2 ☐ FEMALE

K13. What is Adult 2's age?

☐☐ AGE IN YEARS

K14. What is the highest grade or year of school Adult 2 has completed? *MARK ONE ONLY.*

1 ☐ 8TH GRADE OR LESS
2 ☐ 9TH-12TH GRADE; NO DIPLOMA
3 ☐ HIGH SCHOOL GRADUATE OR GED COMPLETED
4 ☐ COMPLETED A VOCATIONAL, TRADE, OR BUSINESS SCHOOL PROGRAM
5 ☐ SOME COLLEGE CREDIT, BUT NO DEGREE
6 ☐ ASSOCIATE DEGREE (AA, AS)
7 ☐ BACHELOR'S DEGREE (BA, BS, AB)
8 ☐ MASTER'S DEGREE (MA, MS, MSW, MBA)
9 ☐ DOCTORATE (PHD, EDD) OR PROFESSIONAL DEGREE (MD, DDS, DVM, JD)

K15. What is Adult 2's marital status?

1 ☐ MARRIED *[GO TO K17]*
2 ☐ NEVER MARRIED
3 ☐ DIVORCED
4 ☐ SEPARATED
5 ☐ WIDOWED
1 ☐ PREFER NOT TO ANSWER *[GO TO K17]*

K16. Does Adult 2 currently live with a romantic partner?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

K17. In general, how is Adult 2's physical health?

1 ☐ Excellent
2 ☐ Very Good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

K18. In general, how is Adult 2's mental or emotional health?

1 ☐ Excellent
2 ☐ Very Good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

K19. Was Adult 2 employed at least 50 out of the past 52 weeks?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

Section L. Health of Child's Mother (PROGRAMMER: Add Timestamp)

L1. A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?

1 ☐ Within the past year (ANYTIME LESS THAN 12 MONTHS AGO)
2 ☐ Within the past 2 years (1 YEAR BUT LESS THAN 2 YEARS AGO)
3 ☐ Within the past 5 years (2 YEARS BUT LESS THAN 5 YEARS AGO)
4 ☐ 5 or more years ago
5 ☐ Never
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

L2. <u>During the past 12 months,</u> have you received any treatment or counseling from a mental health professional? Mental health professionals include psychiatrists, psychologists, psychiatric nurses, and clinical social workers.

1 ☐ Yes
2 ☐ No, but I needed to see a mental health professional
3 ☐ No, I did not need to see a mental health professional *[GO TO L4]*
1 ☐ DON'T KNOW *[GO TO L4]*
1 ☐ PREFER NOT TO ANSWER *[GO TO L4]*

L3. How much of a problem was it to get the mental health treatment or counseling that you needed?

1 ☐ Not a problem
2 ☐ Small problem
3 ☐ Big problem

L4. During your most recent pregnancy, did you have your teeth cleaned by a dentist or dental hygienist?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

L5. Who makes the healthcare decisions for your health?

1 ☐ You
2 ☐ Your spouse
3 ☐ You and your spouse/partner together
4 ☐ Your parents
5 ☐ Someone else, *PLEASE SPECIFY* _____
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

L6. Who makes the healthcare decisions for your child(ren)?

1 ☐ You
2 ☐ Your spouse
3 ☐ You and your spouse/partner together
4 ☐ Your parents
5 ☐ ANOTHER PERSON, *PLEASE SPECIFY* _____
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

The next questions ask about smoking, drinking, and drug use. Please remember that all information you share is confidential. Only members of the research team will have access to this information. Please answer to the best of your ability.

L7. <u>During the past 30 days</u>, on how many days did you smoke cigarettes?

1 ☐ 0 DAYS
2 ☐ 1 OR 2 DAYS
3 ☐ 3 TO 5 DAYS
4 ☐ 6 TO 9 DAYS
5 ☐ 10 TO 19 DAYS
6 ☐ 20 TO 29 DAYS
7 ☐ ALL 30 DAYS
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

L8. Do you drink alcohol, including drinks you brew or make at home?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

L9. During your life, have you ever used any of the following: [READ IF NECESSARY: Betel nut is the seed of the fruit of the areca palm. It is also known as areca nut. Betel nut chewing is an important cultural practice in some regions in south and south-east Asia and the Asia Pacific. It is often chewed wrapped inside betel leaves (paan) or with tobacco (betel quid). Funta, or fronto, is a dark tobacco leaf that can be used for smoking].

		YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
L9a.	**Betel nut**	1 ☐	2 ☐	77 ☐	99 ☐
L9b.	**Vape or e-cigarette**	1 ☐	2 ☐	77 ☐	99 ☐
L9c.	**Funta**	1 ☐	2 ☐	77 ☐	99 ☐
L9d.	**Marijuana (also called grass, pot, weed, or reefer)**	1 ☐	2 ☐	77 ☐	99 ☐
L9e.	**Cocaine, including powder, crack, or freebase**	1 ☐	2 ☐	77 ☐	99 ☐
L9f.	**Heroin (also called smack, junk, or China White)**	1 ☐	2 ☐	77 ☐	99 ☐
L9g.	**Methamphetamines (also called speed, crystal, crank, or ice)**	1 ☐	2 ☐	77 ☐	99 ☐
L9h.	**Ecstasy (also called MDMA)**	1 ☐	2 ☐	77 ☐	99 ☐
L9i.	**Synthetic marijuana (also called K2, Spice, fake weed, King Kong, Yucatan Fire, Skunk, or Moon Rocks)**	1 ☐	2 ☐	77 ☐	99 ☐
L9j.	**Steroid pills or shots without a doctor's prescription**	1 ☐	2 ☐	77 ☐	99 ☐
L9k.	**Prescription pain medicine without a doctor's prescription or differently than how a doctor told you to use it? (Count drugs such as codeine, Vicodin, OxyContin, Hydrocodone, and Percocet)**	1 ☐	2 ☐	77 ☐	99 ☐

IF RESPONDENT CHEWED BETEL NUT, CONTINUE TO L10. ELSE IF RESPONDENT USED ANY OTHER SUBSTANCE IN L9 GO TO L11. ELSE IF NO SUBSTANCES USED, GO TO L12.

L10. During the past 30 days, on how many days did you chew betel nut?

1 ☐ 0 DAYS
2 ☐ 1 OR 2 DAYS
3 ☐ 3 TO 5 DAYS
4 ☐ 6 TO 9 DAYS
5 ☐ 10 TO 19 DAYS
6 ☐ 20 TO 29 DAYS
7 ☐ ALL 30 DAYS
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

L11. Have you been referred to, or did you receive, any form of intervention/counseling/treatment for substance use issues?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

L12. Has your doctor or health care professional told you that you had type 1 or type 2 diabetes?

1 ☐ TYPE 1 DIABETES
2 ☐ TYPE 2 DIABETES
3 ☐ NEITHER *[GO TO L14]*
1 ☐ DON'T KNOW *[GO TO L14]*
1 ☐ PREFER NOT TO ANSWER *[GO TO L14]*

L13. Are you taking medication for this?

1 ☐ Insulin
2 ☐ Pills
3 ☐ Insulin and Pills
4 ☐ I do not take medication
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

L14. Has a doctor or other health care provider EVER told you that you have any of the following conditions…?

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
L14a. Rheumatic heart disease	1 ☐	2 ☐	77 ☐	99 ☐
L14b. Rheumatic fever	1 ☐	2 ☐	77 ☐	99 ☐
L14c. Cervical cancer	1 ☐	2 ☐	77 ☐	99 ☐
L14d. Anemia	1 ☐	2 ☐	77 ☐	99 ☐

L15. How do you describe your weight?

1 ☐ Very underweight
2 ☐ Slightly underweight
3 ☐ About the right weight
4 ☐ Slightly overweight
5 ☐ Very overweight

L16. Which of the following are you trying to do about your weight?

1 ☐ Lose weight
2 ☐ Gain weight
3 ☐ Stay the same weight
4 ☐ I AM NOT TRYING TO DO ANYTHING ABOUT MY WEIGHT

L17. During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day? Add up all the time you spent in any kind of physical activity that increased your heart rate and made you breathe hard some of the time.

1 ☐ 0 DAYS
2 ☐ 1 DAY
3 ☐ 2 DAYS
4 ☐ 3 DAYS
5 ☐ 4 DAYS
6 ☐ 5 DAYS
7 ☐ 6 DAYS
8 ☐ 7 DAYS
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

L18. Are you currently pregnant?

1 ☐ Yes
2 ☐ No *[GO TO M1]*
1 ☐ DON'T KNOW *[GO TO M1]*
1 ☐ PREFER NOT TO ANSWER *[GO TO M1]*

IF RESPONDENT IS NOT PREGNANT AND/OR HAS INFANT 12-MONTHS OR YOUNGER, GO TO M1

These next questions are about Zika virus. Zika virus infection is an illness that is most often spread by the bite of a mosquito but may also be spread by having sex with a man who has the Zika virus.

L19. During your most recent pregnancy, how worried were you about getting infected with Zika virus? Check ONE answer.

1 ☐ Very worried
2 ☐ Somewhat worried
3 ☐ Not at all worried
4 ☐ I HAD NEVER HEARD OF ZIKA VIRUS DURING MY MOST RECENT PREGNANCY *[GO TO M1]*
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

L20. At any time during your most recent pregnancy, did you talk with a doctor, nurse, or other healthcare worker about Zika virus?

1 ☐ No
2 ☐ Yes, a healthcare worker talked with me without my asking about it
3 ☐ Yes, a healthcare worker talked with me, but only after I asked about it
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

L21. During your most recent pregnancy, did you get a blood test for Zika virus?

1 ☐ YES
2 ☐ NO *[GO TO L23]*
1 ☐ DON'T KNOW *[GO TO L23]*
1 ☐ PREFER NOT TO ANSWER *[GO TO L23]*

L22. Were you diagnosed with Zika during your most recent pregnancy?

1 ☐ YES
2 ☐ NO *[GO TO M1]*
1 ☐ DON'T KNOW *[GO TO M1]*
1 ☐ PREFER NOT TO ANSWER *[GO TO M1]*

→ ***[IF YES]*** **which child were you carrying?**

IF PUERTO RICO, GO TO SECTION M

The next questions are about travel during your most recent pregnancy.

L23. During your most recent pregnancy, did you travel to areas with the Zika virus?

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

→ ***[IF YES]*** **During your most recent pregnancy, were you aware of recommendations that pregnant women should avoid travel to areas with Zika virus?**

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

→ ***[IF NO]*** **During your most recent pregnancy, did you avoid travel to areas with the Zika virus because of recommendations that pregnant women should avoid travel to those areas?**

1 ☐ YES
2 ☐ NO
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

Section M. Household Information (PROGRAMMER: Add Timestamp)

M1. How many people are living or staying at this address? ***Include everyone who usually lives or stays at this address. Do <u>not</u> 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
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

M2. 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
1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

M3. **The following** information is for data analysis purposes only so that MCH can better assess services received and potential health care needs among different income groups. Only members of the research team will have access to this information. Your best guess is fine. It does not have to be exact. **Think about your total combined family income for the 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 business, farm, or rent, and any other money income received.**

☐☐,☐☐☐,☐☐☐ TOTAL AMOUNT ($)

1 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

M4. How about if I give you some categories? Would you say your household's income was…

1 ☐ Less than $10,000
2 ☐ $10,000 to less than $15,000
3 ☐ $15,000 to less than $20,000
4 ☐ $20,000 to less than $25,000
5 ☐ $25,000 to less than $35,000
6 ☐ $35,000 to less than $50,000
7 ☐ $50,000 to less than $75,000
8 ☐ $75,000 or more
77 ☐ DON'T KNOW
99 ☐ PREFER NOT TO ANSWER

Section N. FSM Jurisdiction Specific Module (PROGRAMMER: Add Timestamp)

[ONLY ASK THIS QUESTION IF CHILD IS 0-5 or 6-11 YEARS OLD]

I am going to start by asking a few questions about your child's health.

MC1. Does this child currently have developmental delay?

1 ☐ YES
2 ☐ NO *[GO TO MC2]*
77 ☐ DON'T KNOW *[GO TO MC2]*
3 ☐ PREFER NOT TO ANSWER *[GO TO MC2]*

→ ***[IF YES]*** **Would you describe [his/her] developmental delay as mild, moderate, or severe?**

1 ☐ Mild
2 ☐ Moderate
3 ☐ Severe
77 ☐ DON'T KNOW
1 ☐ PREFER NOT TO ANSWER

[ONLY ASK THIS QUESTION IF CHILD IS 0-1 YEAR OLD AND IF BIOLOGICAL MOTHER]

Now I am going to ask a few questions about your health.

MC2. During your most recent pregnancy, did you have any of the following health conditions?

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
MC2a. Gestational diabetes (diabetes that started during this pregnancy)	1 ☐	2 ☐	77 ☐	99 ☐
MC2b. High blood pressure (that started during this pregnancy), pre-eclampsia or eclampsia	1 ☐	2 ☐	77 ☐	99 ☐
MC2c. Depression	1 ☐	2 ☐	77 ☐	1 ☐

MC3. ***[ONLY ASK THIS QUESTION IF CHILD IS 0-5 YEARS OLD AND IF BIOLOGICAL MOTHER]***

Before your new baby was born, did any of the following things happen?

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
MC3a. Someone answered my questions about breastfeeding	1 ☐	2 ☐	77 ☐	99 ☐
MC3b. I was offered a class on breastfeeding	1 ☐	2 ☐	77 ☐	99 ☐
MC3c. I attended a class on breastfeeding	1 ☐	2 ☐	77 ☐	99 ☐
MC3d. I decided or planned to feed only breast milk to my baby	1 ☐	2 ☐	77 ☐	99 ☐
MC3e. I discussed feeding only breast milk to my baby with my family	1 ☐	2 ☐	77 ☐	99 ☐
MC3f. I discussed feeding only breast milk to my baby with my health care worker	1 ☐	2 ☐	77 ☐	99 ☐
MC3g. I chose not to breastfeed my baby	1 ☐	2 ☐	77 ☐	99 ☐

MC4. In the past 12 months, was there any time when you wanted healthcare for yourself, for any reason (such as getting a regular check-up or seeing a doctor when you were sick), but didn't get it?

1 ☐ YES
2 ☐ NO *[GO TO END]*
1 ☐ DON'T KNOW *[GO TO END]*
1 ☐ PREFER NOT TO ANSWER *[GO TO END]*

MC5. Why were you unable to get health care for yourself? *CHECK ALL THAT APPLY.*

	YES	NO	DON'T KNOW	PREFER NOT TO ANSWER
MC5a. I couldn't afford it.	1 ☐	2 ☐	77 ☐	99 ☐
MC5b. I did not know where to go.	1 ☐	2 ☐	77 ☐	99 ☐
MC5c. It was too far away.	1 ☐	2 ☐	77 ☐	99 ☐
MC5d. I could not get there when it was open.	1 ☐	2 ☐	77 ☐	99 ☐
MC5e. I could not get an appointment soon enough.	1 ☐	2 ☐	77 ☐	99 ☐
MC5f. I did not have transportation.	1 ☐	2 ☐	77 ☐	99 ☐
MC5g. I didn't have time to go.	1 ☐	2 ☐	77 ☐	99 ☐
MC5h. I was worried that it wasn't covered under my insurance.	1 ☐	2 ☐	77 ☐	99 ☐
MC5i. Some other reason, *please specify*	1 ☐	2 ☐	77 ☐	99 ☐

(END TIME: ☐☐:☐☐)

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, you, 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.

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0906-0042 and is valid until XX/XX/202X. Public reporting burden for this collection of information is estimated to average .27 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857.