

## Attachment D – Baseline Information Form for Participants

First and Last Name \_\_\_\_\_  
 BEES ID Number \_\_\_\_\_ (Office Use Only)

OMB Control No: 0970-0537  
 Expiration Date: 11/30/2022

YOUR CONTACT INFORMATION		
Name:		
Date of birth:	SSN:	
Current address:		
City:	State:	ZIP Code:
Home phone #: ( )	Cell #: ( )	Work #: ( )
Is this address the best one to mail something to you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Alternative address:		
City:	State:	ZIP Code:
Email address:		
Which is the primary social network you use? <input type="checkbox"/> Facebook <input type="checkbox"/> Twitter <input type="checkbox"/> Instagram <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Decline to answer		
What name do you use in that social network?		
Can we contact you by text message? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer		
What is your preferred mode of contact? (Check all that apply) <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Other (specify): _____		

A. Demographic Information	
A.1 Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Decline to answer
A.2 What is your ethnicity?	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline to answer
A.3 What is your race? (Check all that apply)	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Decline to answer
A.4 Primary language spoken at home	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Decline to answer
A.5 How well do you speak English?	<input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not very well <input type="checkbox"/> Not at all <input type="checkbox"/> Decline to answer
B. Education	
B.1 What is the highest degree or year of school that you have attained?	<input type="checkbox"/> Less than a high school diploma <input type="checkbox"/> High school diploma or equivalent <input type="checkbox"/> Some college or technical training <input type="checkbox"/> Associate's degree or other two-year degree <input type="checkbox"/> Bachelor's degree or higher <input type="checkbox"/> Decline to answer
C. Employment History	
C.1 Are you currently working for pay?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer
C.2 Are you working 35 or more hours per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer
C.3 How many jobs did you work last week?	_____ <input type="checkbox"/> Decline to answer

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<p>C.4 In total, how many months did you work for pay during the past year (including your current job)?</p>	<p>1 <input type="checkbox"/> Did not work      2 <input type="checkbox"/> Less than 4 months      3 <input type="checkbox"/> 4-6 months                  4 <input type="checkbox"/> 7-9 months      5 <input type="checkbox"/> 10 or more months      9 <input type="checkbox"/> Decline to answer</p>							
<p>C.5 Are you currently looking for work?</p>	<p>1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No      9 <input type="checkbox"/> Decline to answer</p>							
<p><i>[If applicable to current state of pandemic, ask C6. Otherwise, skip to C7a.]</i></p>								
<p>C.6a Which of the following statements describes your current employment status due to the COVID-19 pandemic?</p>	<p>1 <input type="checkbox"/> You are working reduced hours due to the pandemic                  2 <input type="checkbox"/> You are not working due to the pandemic                  3 <input type="checkbox"/> Your employment status is not currently affected by the pandemic                  9 <input type="checkbox"/> Decline to answer</p>							
<p><i>(Ask if answered "You are working reduced hours" or "You are not working" to C6a)</i>                  C.6b Are you [working reduced hours] because [OR: not working]: (Check all that apply)</p>	<p>1 <input type="checkbox"/> Your employer reduced employees or hours                  2 <input type="checkbox"/> You need to care for your child or someone else                  3 <input type="checkbox"/> You are concerned for your health or the health of others in your household                  4 <input type="checkbox"/> You are sick with COVID-19 or its lingering symptoms                  5 <input type="checkbox"/> None of these apply      9 <input type="checkbox"/> Decline to answer</p>							
<p><i>(If asked C6b, skip C7a &amp; b)</i>                  C.7a Which of the following statements describes your employment status at any point in the past year due to the COVID-19 pandemic?</p>	<p>1 <input type="checkbox"/> You worked reduced hours due to the pandemic                  2 <input type="checkbox"/> You did not work due to the pandemic                  3 <input type="checkbox"/> Your employment status was not affected by the pandemic in the past year                  9 <input type="checkbox"/> Decline to answer</p>							
<p><i>(Ask if answered "You worked reduced hours" or "You did not work" to C7a)</i>                  C.7b Did you [work reduced hours] because [OR: not work]: (Check all that apply)</p>	<p>1 <input type="checkbox"/> Your employer reduced employees or hours                  2 <input type="checkbox"/> You needed to care for your child or someone else                  3 <input type="checkbox"/> You were concerned for your health or the health of others in your household                  4 <input type="checkbox"/> You were sick with COVID-19 or its lingering symptoms                  5 <input type="checkbox"/> None of these apply      9 <input type="checkbox"/> Decline to answer</p>							
<p><b>D. Household Information</b></p>								
<p>D.1 Which of the following best describes your current housing arrangement during the past month?</p>	<p>1 <input type="checkbox"/> Own your own home or apartment                  2 <input type="checkbox"/> Rent your home or apartment                  3 <input type="checkbox"/> Live in emergency or temporary housing, that is in a shelter or were homeless                  4 <input type="checkbox"/> Live in transitional housing or sober housing                  5 <input type="checkbox"/> Live in a group home                  6 <input type="checkbox"/> Live with friends or relatives and pay rent to them                  7 <input type="checkbox"/> Live with friends or relatives and not pay rent to them                  8 <input type="checkbox"/> Have some other housing arrangement? _____                  9 <input type="checkbox"/> Decline to answer</p>							
<p>D.2 Number of people in your household (including yourself):</p>	<table border="0"> <tr> <td colspan="2"> <p><u>Number of people</u></p> </td> <td rowspan="3" style="vertical-align: top;"> <p>D.3 Do you have a spouse or partner who lives in your household?                              1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No                              9 <input type="checkbox"/> Decline to answer</p> </td> </tr> <tr> <td>Children under age 18:</td> <td>_____ 9 <input type="checkbox"/> Decline to answer</td> </tr> <tr> <td>Adults age 18 or older:</td> <td>_____ 9 <input type="checkbox"/> Decline to answer</td> </tr> </table>	<p><u>Number of people</u></p>		<p>D.3 Do you have a spouse or partner who lives in your household?                              1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No                              9 <input type="checkbox"/> Decline to answer</p>	Children under age 18:	_____ 9 <input type="checkbox"/> Decline to answer	Adults age 18 or older:	_____ 9 <input type="checkbox"/> Decline to answer
<p><u>Number of people</u></p>		<p>D.3 Do you have a spouse or partner who lives in your household?                              1 <input type="checkbox"/> Yes      2 <input type="checkbox"/> No                              9 <input type="checkbox"/> Decline to answer</p>						
Children under age 18:	_____ 9 <input type="checkbox"/> Decline to answer							
Adults age 18 or older:	_____ 9 <input type="checkbox"/> Decline to answer							

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E. Justice Involvement			
<p>E.1 Have you been arrested in the past 12 months?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No  <input type="checkbox"/> Decline to answer</p>	<p>E.2 Have you ever been convicted of a crime?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No  <input type="checkbox"/> Decline to answer</p>	<p>E.3 Are you currently on parole or probation?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No  <input type="checkbox"/> Decline to answer</p>	<p>E.4 Have you ever been incarcerated?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No  <input type="checkbox"/> Decline to answer</p>

F. Benefit Receipt	
<p>F.1 For this next question, please consider only yourself, not anyone else in your household. Have you received a check or electronic payment from the Social Security Administration because of a disability in the past year as an adult? (Probe: This could have been payments from Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI).)</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> Don't know      <input type="checkbox"/> Decline to answer</p>
<p>F.2 Are you currently receiving checks or electronic payments from the Social Security Administration because of a disability?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> Don't know      <input type="checkbox"/> Decline to answer</p>
<p>F.3 As an adult, in the past five years have you applied to the Social Security Administration to receive checks or electronic payments because of a disability?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> Don't know      <input type="checkbox"/> Decline to answer</p>
<p>F.4 Are you currently awaiting a decision by the Social Security Administration on a pending disability application?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> Don't know      <input type="checkbox"/> Decline to answer</p>
<p>F.5 During the past year, did <u>you or anyone in your household</u> receive income or assistance from any of the following sources? (Check all that apply)</p>	<p><input type="checkbox"/> Disability benefits from SSA (SSI or SSDI)  <input type="checkbox"/> TANF  <input type="checkbox"/> Unemployment insurance (UI)  <input type="checkbox"/> Worker's compensation  <input type="checkbox"/> Short-term disability  <input type="checkbox"/> Food stamps/SNAP/Basic Food</p> <p><input type="checkbox"/> WIC  <input type="checkbox"/> HCV/Section 8/public housing  <input type="checkbox"/> Veterans benefits  <input type="checkbox"/> Medicaid/Apple Health or CHIP/Apple Health for Kids  <input type="checkbox"/> None of the above  <input type="checkbox"/> Decline to answer</p>
G. Substance Use	

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G.1 How many days in the past 30 have you experienced difficulty with alcohol? [IF 0, SKIP TO G.6.]	_____ days 99 <input type="checkbox"/> Decline to answer
G.2 How troubled or bothered have you been in the past 30 days by these alcohol problems?	1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> Slightly 3 <input type="checkbox"/> Moderately 4 <input type="checkbox"/> Considerably 5 <input type="checkbox"/> Extremely 9 <input type="checkbox"/> Decline to answer
G.3 How important to you now is treatment for these alcohol problems?	1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> Slightly 3 <input type="checkbox"/> Moderately 4 <input type="checkbox"/> Considerably 5 <input type="checkbox"/> Extremely 9 <input type="checkbox"/> Decline to answer
G.4 How many days in the past 30 have you used....? [“Decline to answer” options will appear for each substance.]	Alcohol – Any use at all 99 <input type="checkbox"/> Decline to answer Alcohol – To Intoxication 99 <input type="checkbox"/> Decline to answer
G.5 How much money would you say you spent during the past 30 days on alcohol?	\$ _____ 99 <input type="checkbox"/> Decline to answer
G.6 How many days in the past 30 have you experienced difficulty with drugs? [IF 0, SKIP TO H.1.]	_____ days 99 <input type="checkbox"/> Decline to answer
G.7 How troubled or bothered have you been in the past 30 days by these drug problems?	1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> Slightly 3 <input type="checkbox"/> Moderately 4 <input type="checkbox"/> Considerably 5 <input type="checkbox"/> Extremely 9 <input type="checkbox"/> Decline to answer
G.8 How important to you now is treatment for these drug problems?	1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> Slightly 3 <input type="checkbox"/> Moderately 4 <input type="checkbox"/> Considerably 5 <input type="checkbox"/> Extremely 9 <input type="checkbox"/> Decline to answer
G.9 How many days in the past 30 have you used....?	
Heroin Methadone (outside of methadone maintenance treatment) Other opioids/opiates/ painkillers Barbiturates Other sedatives, hypnotics, or tranquilizers Cocaine Amphetamines Cannabis Hallucinogens More than one substance per day (including alcohol)	_____ days 99 <input type="checkbox"/> Decline to answer _____ days 99 <input type="checkbox"/> Decline to answer _____ days 99 <input type="checkbox"/> Decline to answer _____ days 99 <input type="checkbox"/> Decline to answer _____ days 99 <input type="checkbox"/> Decline to answer _____ days 99 <input type="checkbox"/> Decline to answer _____ days 99 <input type="checkbox"/> Decline to answer _____ days 99 <input type="checkbox"/> Decline to answer _____ days 99 <input type="checkbox"/> Decline to answer _____ days 99 <input type="checkbox"/> Decline to answer
G.10 How much money would you say you spent during the past 30 days on drugs?	\$ _____ 99 <input type="checkbox"/> Decline to answer
<b>H. Mental Health</b>	
H.1 During the last 30 days, about how often did	
H.1a ...you feel so depressed that nothing could cheer you up?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 99 <input type="checkbox"/> Decline to answer
H.1b ...you feel hopeless?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 99 <input type="checkbox"/> Decline to answer

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H.1c ...you feel restless or fidgety?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
H.1d ...you feel that everything was an effort?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
H.1e ...you feel worthless?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
H.1f ...you feel nervous?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
<b>I. Disability Status</b>	
I.1 Are you deaf or do you have serious difficulty hearing?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
I.2 Are you blind or do you have serious difficulty seeing, even when wearing glasses?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
I.3 Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
I.4 Do you have serious difficulty walking or climbing stairs?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
I.5 Do you have difficulty dressing or bathing?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
I.6 Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
I.7 Does a physical, mental, or emotional condition limit the kind or amount of work you can do?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know 9 <input type="checkbox"/> Decline to answer
<b>J. Health</b>	
J.1 In general, would you say your health is:	1 <input type="checkbox"/> Excellent 2 <input type="checkbox"/> Very good 3 <input type="checkbox"/> Good 4 <input type="checkbox"/> Fair 5 <input type="checkbox"/> Poor 9 <input type="checkbox"/> Decline to answer
J.2 The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?	
J.2a Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1 <input type="checkbox"/> Yes, limited a lot 2 <input type="checkbox"/> Yes, limited a little 3 <input type="checkbox"/> No, not limited at all 9 <input type="checkbox"/> Decline to answer
J.2b Climbing several flights of stairs	1 <input type="checkbox"/> Yes, limited a lot 2 <input type="checkbox"/> Yes, limited a little 3 <input type="checkbox"/> No, not limited at all 9 <input type="checkbox"/> Decline to answer
J.3 During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?	
J.3a Accomplished less than you would like	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.3b Were limited in the kind of work or other activities	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.4 During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?	
J.4a Accomplished less than you would like	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.4b Did work or other activities less carefully than usual	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer

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J.5 During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?	1 <input type="checkbox"/> Not at all 2 <input type="checkbox"/> Slightly 3 <input type="checkbox"/> Moderately 4 <input type="checkbox"/> Considerably 5 <input type="checkbox"/> Extremely to answer 9 <input type="checkbox"/> Decline
J.6 These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...	
J.6a Have you felt calm and peaceful?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.6b Did you have a lot of energy?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.7 Have you felt downhearted and depressed?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.8 During the past 4 weeks, how much of the time have your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?	1 <input type="checkbox"/> All the time 2 <input type="checkbox"/> Most of the time 3 <input type="checkbox"/> Some of the time 4 <input type="checkbox"/> A little of the time 5 <input type="checkbox"/> None of the time 9 <input type="checkbox"/> Decline to answer
J.9 During the past year, have you received help or treatment for mental health problems?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
<b>K. Housing and Household Information</b>	
K.1 During the past two years, have you ever been evicted or forced by your landlord to move when you didn't want to?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> In the midst of an eviction 4 <input type="checkbox"/> Don't know 9 <input type="checkbox"/> Decline to answer
K.2 In the past 12 months was there ever a time when, because of cost, you or your household was not able to:	
K.2a Pay your rent	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
	[If Yes] How often did this happen in the past 12 months? 1 <input type="checkbox"/> 1 Month 2 <input type="checkbox"/> 2 or 3 months 3 <input type="checkbox"/> 4 to 6 months 4 <input type="checkbox"/> 7 or more months 9 <input type="checkbox"/> Decline to answer
K.2b Pay your utility bills	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
	[If Yes] How often did this happen in the past 12 months? 1 <input type="checkbox"/> 1 Month 2 <input type="checkbox"/> 2 or 3 months 3 <input type="checkbox"/> 4 to 6 months 4 <input type="checkbox"/> 7 or more months 9 <input type="checkbox"/> Decline to answer
K.2c Pay for food needed	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer
	[If Yes] How often did this happen in the past 12 months? 1 <input type="checkbox"/> 1 time 2 <input type="checkbox"/> 2 or 3 times 3 <input type="checkbox"/> 4 to 6 times 4 <input type="checkbox"/> 7 or more times 9 <input type="checkbox"/> Decline to answer
K.2d Pay for child care	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Decline to answer

